Cancer Itineraries Across Borders in Post-invasion Iraq

War, Displacement, and Geographies of Care

By

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Abstract

Recent studies have documented how successive wars and sanctions have led to a deterioration of the Iraqi national health care system and the emergence of geographies of care spanning beyond the borders of the state. Focusing specifically on cancer and oncology, this dissertation develops an ethnography of these geographies by accompanying patients and their companions across provinces and borders in their pursuit of treatment. In post-invasion Iraq, lack of security and an absence of meaningful reconstruction compels an increasing number of cancer patients from central and southern Iraq to piece together treatments through movement. They travel northward to the emerging public oncology hubs of Kirkuk, Erbil and Sulaymaniyah in addition to regional private centers in Amman, Istanbul and Beirut. The ethnography follows such illness journeys over multi-year periods, accompanying patients as they traverse sites of treatment in Iraq and Lebanon. These itineraries constantly intersect with ongoing conditions of war and forced displacements, in addition to violent events from past wars that remain imprinted on the body and the roadways.

Part I is an attempt to engage with conversations in medical oncology, geography, and refugee studies – fields that shape health policy in the region. In keeping with this genre of scholarship the material is molded into case studies, drawing from hospital-based fieldwork in Sulaymaniyah, Kirkuk, Erbil, and Beirut. The cases extend beyond the circumscribed spatiality of the hospital through a methodology of accompaniment between sites of treatment. Part II consists of an extended ethnographic case study of a single cancer journey. It shows how dynamics of conflict shape a kinship network's evolving justifications for either granting or withholding resources towards a family

member's high-cost cancer treatments. The ethnography eventually moves with the case across borders to Lebanon's oncology centers. In Lebanon the patient and his travel companion encounter a range of non-medical actors who provide forms of support for both the disease and the pains of life under war. Following a cancer itinerary across borders reveals how a wide array of unforeseen social relations are brought into the scene of care through movement, indicating that emerging therapeutic geographies are not solely oriented around the healing promised by biomedicine. Iraqis' cancer journeys rework anthropological understandings of the spatial, social, and temporal breadth of chronic illness in a region of war.

Readers: Clara Han, Veena Das, Niloofar Haeri, Jeremy Greene and Sarah Parkinson

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INTRODUCTION

In 1999 Sitt Mariam, an Assyrian school teacher from Mosul, developed a painful growth in her breast.[1] Doctors identified the growth as cancerous, and she soon underwent a surgery and chemotherapy. When it came time for radiotherapy, she learned from nurses that the linac available in the Mosul Nuclear Medicine Center was not operating at full capacity — a consequence of United Nations sanctions and the resulting blockages on materials. Hearing that the Baghdad linac was currently operating well, she decided it would be best to visit relatives in the capital city and to undergo radiotherapy there. She spent nearly two months in Baghdad and then returned to Mosul, subsequently undergoing several years of follow up. The disease laid dormant. Also in 1999, Abu Sujjad, an engineer from the southern province of Najaf, developed a growth in his neck. Doctors in Najaf identified the tumors as cancerous and conducted a surgical operation. Subsequently he was referred to Baghdad for chemotherapy. Like Sitt Mariam, Abu Sujjad entered into over a decade of follow up. The disease was quiet, for now.

The routes described above align with the geographical distribution of oncology officially acknowledged by Iraqi oncologists in the 1990s up to the fall of the government in 2003. Baghdad was understood to be the center of this geography, with the major cities of Basra and Mosul as secondary oncology hubs. At a 2000 oncology conference in Mosul, each province provided a report on the status of oncology capacity. The Najaf delegation's report read: *Surgical treatment is the only available modality. Patients are sent to Baghdad for radiotherapy and chemotherapy*. The southern provinces of Karbala,

[1] All names throughout the dissertation are pseudonyms. All collection and presentation of the data has conformed to the policies and procedures of the Internal Review Board (IRB) at Johns Hopkins University.

Diwaniya, Al Muthana, Kut, and the central/northern province of Salahadin used exactly the same language as Najaf: *Surgical treatment is the only available modality. Patients are sent to Baghdad for radiotherapy and chemotherapy*. Thiqar and Meysan provinces issued a slight variation, reporting that patients were sent to Baghdad or Basra for chemotherapy, and Baghdad for radiotherapy. Kirkuk reported referrals to either Mosul or Baghdad for chemotherapy and radiotherapy. The Baghdad delegation reported the availability of all major modalities (surgery, chemotherapy, and radiotherapy), but at a reduced capacity due to UN sanctions: *Chemotherapy drugs are available but on irregular bases. Treatment courses are usually interrupted and incomplete. This has led to increase mordacity, shorter survival, and increased mortality. Sanctions on Iraq are the cause of these shortages and their consequences…*"[2]

Three provinces did not issue reports at the 2000 conference: Dohuk, Sulaymaniyah, and Erbil — the majority Kurdish and semi-autonomous provinces. During the Sanctions era (1991 - 2003), the three provinces were politically, economically and socially segregated from the rest of the country through the imposition of the No-fly zone and the establishment of Kurdish autonomy (Tripp 2000: 217). This is not to say that there were no routes of connection and exchange between the Kurdish provinces and the rest of the country. Nearby Mosul received many Kurdish patients throughout the 1990s.[3] At the Mosul oncology conference, the Mosul delegation reported administering treatment to "667 patients from northern provinces," a euphemistic

[2] Ministry of Health, Ninewa Directorate of Health (2000). 7th Mosul Oncology Conference. Program and Abstracts. 24 - 26 October.

[3] Interview with Dr. Layth Mula Hussein, Head of Radiotherapy at Zhianawa Cancer Center, Sulaymaniyah, Iraq; Formerly Specialist at Mosul Republican Hospital, Mosul, Iraq, November 2016.

reference towards patients from Dohuk, Sulaymaniyah and Erbil. Baghdad also received Kurdish patients from the north. During the 1990s roads leading south towards Baghdad came to a final peshmerga checkpoint near Kirkuk, at which time patients desiring advanced care in the capital would disembark and walk to the Iraqi side controlled by the Baathists – usually with some degree of concern over the handling they would receive by security personnel before boarding Baghdad-bounded taxis.

Now in 2016, both Sitt Mariam and Abu Sujjad are undergoing treatments again — in the once neglected Kurdish provinces of Erbil and Sulaymaniyah. In an interview at Erbil's public Nanakali Cancer Hospital, Sitt Mariam told me how she fled Mosul to Erbil after the rise of the Islamic State (*daesh*), and then the disease resurfaced during the process of resettlement. She considered the direction of her displacement fortunate in one respect: She now received chemotherapy in Erbil's public centers, where they "have much better treatment than Baghdad or Mosul," she noted. As for Abu Sujjad, he discovered the return of his disease in 2013. Though Najaf and other southern areas were spared from *daesh* violence and displacement, in Abu Sujjad's estimation earlier periods of conflict had removed the desirability of more proximate care options in Najaf or Baghdad. He explained that "all the doctors left Baghdad after the fall (*soqood*) of the government, and many came here." He regularly travelled by plane from Najaf to Sulaymaniyah for treatments. Baghdad oncologists have striven to maintain advanced centers for cancer research and treatment amidst great challenges; [4] however, as we noted in Dewachi et al. 2014, the overall lack of security and militarization of state institutions

[4] See Alwan and Kerr (2018). I am grateful to Dr. Alwan, head of Baghdad University's National Cancer Research Center, for her counsel and insistence that I build on the dissertation with research in Baghdad. For the book manuscript I intend to conduct fieldwork in Baghdad in coordination with Al Amal Cancer Center.

has tarnished hospitals' former safe haven status and position of trust.[5] It is in this context that northern Iraq or Kurdistan has absorbed an increasing patient load from the very provinces that once served country-wide medical needs. [6]

Indeed, the provinces of Erbil, Sulaymaniyah, and Dohuk have received many doctors since 2003 due to the stability of the region during the 2003 -2011 US Occupation era, in addition to the considerable investments in public medicine made by the semi-autonomous Kurdish Regional Government (KRG). A cancer ward opened in Sulaymaniyah's teaching hospital in 2003. Founded four years later in 2007, Sulaymaniyah's Hiwa Cancer Hospital is now second only to Baghdad's Amal Cancer Hospital in terms of overall patient volume country-wide.[7] Less equipped hospitals from the nearby provinces of Kirkuk and Diyala send patients to Sulaymaniyah. One oncologist in Kirkuk told me, "Sometimes I feel we're just a transit center to Sulaymaniyah or Erbil."[8] Erbil's Nanakali Cancer Hospital, likewise a product of the post-2003 era, is not far behind Hiwa in terms of overall patient load, absorbing patients from war-torn Mosul in addition to regular referrals from surrounding provinces.[9] The KRG's revenue from oil sales and its control over budget priorities of the provinces under

[5] Baghdad remains an enormously important center for oncology in Iraq. In highlighting the emergence of new oncology hubs in Kurdistan and across borders, the aim is not to diminish the ongoing role of the capital city in providing care for Iraqis.
[6] Using the language of 'northern Iraq' or 'the north' is off-putting in certain contexts, as it implies an essential Iraqi unity, a unity which some (certainly not all) residents of Kurdish provinces reject. "I'm not your north" (*ani mo shimalak*) was a phrase I occasionally heard uttered by Kurds towards Arab friends with whom they could risk such a strong statement. I have used the language of the 'north' as well as the language of 'Kurdistan' in order to reflect that both are variously in use to describe this region depending on whom one is speaking.
[7] Interviews with Dr. Kadham Farook Namiq and Dr. Dosti Othman, Hiwa Hospital, Sulaymaniyah, Iraq, November 2016.
[8] Interview with Dr. Mohammed Saleem, Kirkuk Cancer Center, Kirkuk, Iraq, December 2016.
[9] Interviews with Dr. Raman Thawrat, Nanakali Hospital, Erbil, Iraq, January 2017.

its purview has given the Kurdish Ministry of Health the ability to build and develop medical institutions at a scale that federal provinces do not possess. Much of this government investment has significantly lessened since the financial crisis of 2014 following the rise of *daesh* and the fall of oil prices, forcing public cancer hospitals such as Hiwa and Nanakali to raise funds through private Kurdish donors and foundations.[10] It is important to note that the KRG makes investments in the health facilities in Kirkuk, Diyala, and Salahadin – areas that the KRG considers part of Kurdistan; yet, the level of investment in the so-called 'disputed territories' is likely to lessen now that the federal government has reasserted control over these areas since October 2017.

In addition to regular treatments in Erbil, Sitt Mariam and Abu Sujjad have both undergone PET scans in Beirut, Lebanon due to the lack of working linacs in Iraq — a product of the country's history of war. (Iraq's only Cyclotron, which produces the FDG material necessary for PET machines, was allegedly bombed by the Israeli military in 1981 according to a number of sources who preferred not to be cited. In 2002 the Ministry of Health made plans to restore a Cyclotron to Saddam Cancer Center, but the US-led invasion stalled this initiative. More recently there have been plans to establish a cyclotron and three public PET facilities in Baghdad, Mosul and Basra. [11] Corruption as well as the war against *daesh* has derailed these plans for now.) With persistent war-related gaps in Iraq's technological infrastructure converging with the opening of borders to travel after 2003, regional cities such as Beirut have emerged as important hubs for PET scans, chemotherapy, and cancer surgeries. According to the lead oncologist at the

[10] Interview with Mrs. Nian Abdullah, President, Hiwa Foundation, Sulaymaniyah, Iraq, May 2017.
[11] Correspondence between the author and Dr. Layth Mula-Hussein, May 2018.

American University of Beirut's cancer center, 20 percent of all new admissions and 60 percent of daily visits now involve Iraqis traveling to the city for treatment – up from a negligible number just 12 years ago.[12] The medical attaché at the Iraqi Embassy in Beirut claims that tracking the total numbers of cancer patients arriving to Beirut is impossible as the numbers are too vast and they are spread across dozens of hospitals, rarely registering with the Embassy.[13]

While the majority of the overall patient population from Iraq in Beirut comes on funds raised through kinship networks, a small portion travels and receives complementary treatment through state funded delegations; however, many of these government-funded cases generate long-term financial burdens which are placed on the shoulders of patients due to the considerable expenses of follow up,[14] a theme to be discussed in detail in the ethnographic cases. Two of the cases (in chapter 2) detail the journeys of patients receiving bone marrow transplants in Beirut on the Iraq Ministry of Health's budget. Not only was coverage limited to the bone marrow transplant period in Beirut, the entire bone marrow transplant program was itself short-lived, spanning 2013 and 2014 before the financial crisis of 2014 and the rise of *daesh* curtailed cancer-related funds for treatments abroad. Any remaining resources in the Iraqi Ministry of Health's

[12] Interview with Dr. Ali Shamseddine, American University of Beirut, Beirut, Lebanon, June 2015.
[13] Interview with the medical attache, Embassy of Iraq in Lebanon, Beirut, Lebanon, March 2016.
[14] Conversations with Dr. Raafat Alameddine, oncology fellow at the American University of Beirut, helped shed light on the fact that AUB oncologists have grown concerned about the long-term fate of government-funded patients who received complex procedures such as bone marrow transplants in Beirut in 2013 and 2014, only to return to an oncology apparatus in Iraq that does not have the capacity to follow up with such patients.

budget for cross-border care were largely transferred to burn/blast cases benefitting soldiers fighting *daesh*.[15]

This cursory description of the geographical redistribution of oncology aligns with the concept of a "therapeutic geography," which we have described as the geographic redistribution of healthcare under conditions of war (Dewachi et al. 2014). Wars have not merely destroyed Iraq's once robust national health care system but have led to a reconfiguration of the geography of care beyond the country's national borders. In Dewachi et al. (2014), our team of coauthors sought to emphasize the cross-border and transnational dimension of this reconfiguration, highlighting the enormous populations of displaced Iraqis undergoing treatments in neighboring countries as well as individuals who travel across borders for treatments unavailable at home. Furthering the study of therapeutic geographies requires a merging of care-seeking pathways beyond and within Iraq's national borders. As the cases of Sitt Mariam and Abu Sujjad indicate, the post-2003 topography of oncology includes not only new cross border hubs but also cities within Iraq which were previously peripheral to the distribution of care. In 1999, the notion that Sitt Mariam would one day prefer Erbil over Baghdad and Mosul for oncology would have seemed preposterous to patients and oncologists alike, just as much or perhaps more so than the prospect of traveling to Beirut for a PET scan.

The primary means of exploring these shifts in the geography of care will be case histories of individual patients, drawing from the language and knowledge they use to describe their experiences. One analytical benefit to the study of a disease that often

[15] Conversations with Dr. Ghassan Abu Sitta, head of Plastic Surgery at the American University of Beirut, have illuminated the extent of the hospital's work with Iraqi cases of this nature, which are largely made up of Iraqi soldiers suffering from wounds from the fight with *daesh*. Dr. Omar Dewachi has also worked on this issue extensively.

presents itself in repetitive, long-term sequences is the capacity to study how routes of care are transformed over time. [16] While I rely on archival materials such as the Mosul Oncology Conference to provide documentary support to certain claims, my primary window into Iraq's changing geography of oncology is the experience of patients and they ways in which they project themselves in the journey for treatment. Tracking these itineraries over several years and across borders provides a lens into the emergence of a geography of cancer care.

The focus on case studies and patient experiences builds upon a study by Sarah Parkinson and Orkideh Behrouzan (2015):

> "Dewachi et al. compellingly present this perspective as a counterpoint to the more state-centric health systems framework. Yet to take their approach a step further, 'mapping' evolving therapeutic geographies should capture both broad transformations such as regionalization and 'bottom-up' feedback based on the situated practices and knowledge of refugees themselves… This extension underscores the inherently variable microdynamics of healthcare access, including factors such as the local security environment and the field of (non)state providers. Yet it also, and perhaps most importantly, affords space for refugees' own agency and resourcefulness, which are undertheorized in current

[16] Mobilities across borders are shaped by the features of particular cancer diseases. Rapidly progressing cancers may thrust a patient across borders in pursuit of treatment during the days and months before death. Beirut's lax border entry policies towards Iraqi citizens encourage a high frequency of such cases, as one can transport a rapidly deteriorating patient from Baghdad to Beirut with little planning within a few hours. Other 'slow' cancers may generate a multi-year treatment itinerary spanning Iraqi and regional cities like Beirut. The emphasis in this dissertation is on cases with long-term chronicities and follow ups.

> conceptualizations of therapeutic geographies." (Parkinson & Behrouzan 2015: 326)

Parkinson & Behrouzan's intervention is to place "lived experience" at the center of conceptualizations of therapeutic geographies (2015: 326). Accordingly, they track the urban movements of two Syrian refugees as they traverse Beirut in pursuit of health care. Indeed, we cannot adequately speak of changing geographies of care without understanding the experiences of the people whose very mobilities make and remake this geography.

Turning to individual experiences of therapeutic geographies raises the question of scale. As Iraqis move across cities, provinces, and borders in pursuit of care, how do they understand and navigate the spatial and temporal relations connecting these varied sites of treatment? Parkinson and Behrouzan suggest that experiences of a geography of care are essentially situated at a "micro" level (2015: 326) – i.e., in contrast to a "macro" level aggregation of population movements across borders. They seek to "develop the concept of therapeutic geographies in a way that allows micro level experiences to inform macro understandings…" (2015: 326). I take up the call for exploring the lived experience of therapeutic geographies while stressing the need for a shift in the understanding of scale. As Das (2007: 3-4) has argued, questions of scale appear differently when one enters into the "concrete relations" of specific life worlds.[17] She elaborates: "Describing the scale of sociality depends on the perspective of the person viewing the social field(s). To say, for instance, that the level of the family or clan is 'small scale' and the scale of the city is 'large scale' is to ignore the fact that different

[17] I understand "concrete relations" as those which bear upon and shape the life of a specific subject – i.e., Sitt Mariam situated within *her* world of doctors, family members, adversaries, etc.

social actors will construct the relations between different objects in their social field differently" (2007: 4). In a similar vein, anthropologically there can be no understanding of the experience of therapeutic geographies as 'micro' or 'macro' or 'local' or 'transnational' divorced from the perspective of the person in pursuit of care. One arrives at a phenomenological sense of scale only through attempts to document the spatial and social relations described and experienced by those inhabiting and moving across a world. This methodological orientation is particularly important in contexts of war where temporal and spatial frames are highly indeterminate and unstable (Al Mohammad 2012; Lubkemann and Hoffman 2005). We will have no capacity to grasp cancer patients' perceptions of spatial and temporal relations without entering into the world of relationships in which their sense of a geography of care emerges.

Entering into and remaining within the life world of a sick person raises particular methodological challenges in the case of Iraqis' cancer journeys: How does an ethnographer insert herself into a field of relations that is constantly on the move, and over the lengthy course of a chronic illness? Moving *across* relations that spread across wide physical distance is already logistically and physically taxing, as noted by Hage (2005) in a study of a Lebanese family with poles of concentration across the globe. Moving *with* actors and relations that uproot themselves and travel raises additional challenges, especially when one studies migrants and travelers outside the global elite and in a region of ongoing wars. In contexts with militarized borders and crossings, the presence of an anthropologist acting in an accompaniment role may in some cases imperil the already fragile power relations between those who move and the security actors they face along the way (De Leon 2015; Allen 2008).

Accordingly, the dissertation experiments with different methodological possibilities for accompanying and *journeying with* patients. The first chapter begins with hospital-based interviews and gradually moves towards embeddedness within the specific life worlds of patients. The field research involves accompanying patients across varied spaces of care, including hospitals, hotels, city streets, airports, checkpoints, homes, and places of work. The delimitation of the 'field' shifts unpredictably and in some cases haphazardly. This lack of systematicity is largely a function of the inevitable contingencies of cancer trajectories. While chemotherapy may provide a semi-regular schedule that maps onto a regular pattern of movement (e.g., Abu Sujjad's monthly trips to Erbil from Najaf), the movements emerging from the occurrence of unexpected symptoms, war-related events, and economic disasters come unbidden. As the ethnography will show, opportunities to accompany patients across borders have often arisen through entirely chance encounters. The center and limit of the field was never a transparent question.

The methodology and analysis attempt to mold to the chronicity and spatial multi-directionality of cancer journeys. Cancer journeys allow us to merge categories of cross-border healthcare mobilities which are typically considered distinct, namely, "refugee healthcare" on the one hand and "medical travel" or "medical tourism" on the other. At first glance Sitt Mariam's case is recognizable within studies of internally displaced persons' (IDPs) and refugees' healthcare. Sitt Mariam is internally displaced from Mosul to the semi-autonomous Kurdish region after the rise of *daesh* and now receives treatment in the latter — a familiar trajectory that aligns with studies depicting the displaced as seeking care within the spatial and political bounds of their new "host

communities" (Mowafi 2011). When she boards a plane and travels internationally to Beirut for a PET scan, this segment of her trajectory appears more akin to scholarly conversations on "medical tourism" or "international treatment journeys" (Kangas 2010; Crush and Chikanda 2015). A single journey for cancer care involves overlapping displacements, travels, and movements over years and even decades.[18]

We must develop methodologies that allow us to track experiences of these diverse mobilities. In formulating such methods, we cannot presume that the 'local' remains the scene of the intimate zone of lived experience and face to face relations, while the regional or global is the domain of the abstract and distant (Amin 2004). The fact that this narrow spatialization of experience remains in force among many theorists, geographers included, is surprising given the move in health geography towards "plural spatial connections" and "relational" maps (Amin 2004: 34). This dissertation will track illness experiences that call into question the spatial and scalar categories we place around different forms of cross-border treatment itineraries.

Importantly, a turn towards lived experience does not entail an individuation of the illness journey. Historian Julie Livingston's (2012) research in a Botswana oncology ward explores how 'cancer' is gradually constituted through clinical interactions between a complex set of actors including the oncologist, nurses, patients, family members and technological devices. The illness experience arises within a network of actors. Extending the spatiality of this work, I will begin the ethnography inside Iraqi oncology clinics but soon take the locus of the research outside of their walls, exploring experiences of cancer

[18] A regionalized distribution of oncology is a phenomenon meriting serious study in numerous oncology contexts across the so-called Global South as well as the United States and Europe. For instance, Carlo Caduff is working on this issue in India through an exploration of the country's 'cancer grid.' Comparative studies across contexts are needed.

as embedded within contexts and assemblages of relations emerging over the course of a treatment itinerary. Each cancer journey maps out not only a series of movements but a constellation of relations, drawing a web of connections between institutions and persons spread out across wide geographies.

In a similar move, recent anthropological work has suggested that studies of patients' illness narratives (Kleinman 1988), which have long been a primary site for the exploration of the illness experience in anthropology, too often create an overly individualized picture of illness and elide the broader fields of persons and institutions within which illness is embedded (Das 2014; Han 2012). This important critique, which I find to be valid, is not intended to suggest that patients' reflections on their illness journeys are inherently individualizing, however. It is more a question of emphasis and method. [19] Recent studies conducted in Turkey and Iran have shown how people's illness narratives extend beyond the individual and reveal memories of war, collective suffering, and deaths of loved ones (Dole 2012; Behrouzan 2016). Dole and Behrouzan are based in contexts of conflict or political violence in which the layers of suffering – and the attempts of the ill to articulate the pains of life – are not neatly centralized around the event of the illness itself.

Similarly, Iraqis with cancer articulate the experience of the disease in ways that cut across diverse sets of relationships, events, and mobilities. Their stories are essential for gaining a glimpse into the full temporal expanse of the illness given that researchers

[19] While Kleinman himself insists that illness narratives reveal a complex web of relations, upon close examination the emphasis of the narratives he constructs is the "personal world of suffering" and the "complex inner language of hurt, desperation..." (Kleinman 1988: 29). He is focused on the patient's language of suffering – her terms, her idioms, her interpretations of social relations, and so on. The patient remains at the center of the account because the patient-doctor or patient-researcher relationship structures the encounter in which Kleinman is situated.

are almost inevitably entering the everyday lives of cancer patients in the midst of the illness journey and not from its inception. Patients' articulations of the illness will figure prominently in the study alongside other voices and materials.

Method and Chapters

Anthropologists of mobility have long called for multi-sited studies (Marcus 1995). While my research spans multiple hospitals and cities, with Hage (2005) the approach of this dissertation is to treat disparately located nodes as one interconnected site — i.e., a geography of care. Part I examines this geography from the vantage point of two emerging treatment hubs: The Kurdish North of Iraq (chapter 1) and Beirut, Lebanon (chapter 2). The data presented in Part I draws upon the stories of patients and their "companions" (*murafiqeen*) as well as various forms of participant observation. Departing from ethnographies of oncology hospitals (Livingston 2012: Long et al. 2008), again I avoid the circumscribed spatiality of these studies and accompany patients in their movements *between* hospitals, hotels, checkpoints, airports, and other sites along the therapeutic pathway. Iraqi oncologists with whom I worked immediately understood the logic of this method, as they would be the first to inform me that public deficits in pharmaceuticals and technology required nearly all patients and especially IDPs to piece together treatments between different provinces — and in many cases multiple countries.

In chapter 1 entitled "Journeys to the Kurdish North: Rethinking Therapeutic Geographies," I present ethnographic and interview data collected within three public oncology centers in Sulaymaniyah, Erbil, and Kirkuk.[20] I elaborate the journeys of

[20] In Kirkuk federal and KRG administrative bodies have vied for influence over the province, although recently since October 2017 a mix of federal authorities and militia elements have taken

patients who travel or are displaced to the north from central and southern regions of Iraq, and who may also subsequently sojourn across borders to Syria, Lebanon or Jordan for more advanced modalities of care. The main question of the first chapter pertains to issues of scale grounding much of the broader dissertation: Departing from a nested model that divides mobilities into prefigured scalar categories, I will show how borders and disparately located treatment sites are embedded within everyday struggles to obtain treatment under conditions of war.

Figure 0.1: Research Sites[21]

I conducted 28 interviews at Nanakali Cancer Hospital (Erbil); 44 at Hiwa Cancer Hospital (Sulaymaniyah); and 20 at Kirkuk Cancer Center (Kirkuk) during 2016 and 2017. The chapter highlights several cases that reflect patterns in the larger data set.

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over the bulk of local administration and security. It is important to include Kirkuk in the study as the province is strongly linked to both federal and Kurdish health care systems.

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In chapter 2 "Journeys to Beirut: Financial Toxicity and Cross-border Care," I examine ethnographic and interview data collected in Beirut, Lebanon. The city has become an important cross-border treatment hub for PET scans as well as all major treatment modalities (surgery, chemotherapy, radiotherapy). I conducted ethnographic fieldwork in the hotels and apartments where Iraqis reside amidst treatment, in addition to 45 case interviews between 2014 and 2017.[22] One third of the Beirut data set includes patients from government-sponsored delegations. Though a small number as compared to the overall Iraqi patient population, the Iraqi Ministry of Health has facilitated cross-border movements for select groups of patients through multimillion dollar contracts with private hospitals in Lebanon, Turkey, Jordan and India. Specifically, I look at a delegation of patients receiving bone marrow transplants on the "government's account" – each patient allocated $140,000 for the treatment and follow up in Beirut.

The apparent disparity between self-funded and government-funded patients is not as wide as it appears, however. The chapter's analysis consists of a longitudinal comparison between self-funded and government-funded trajectories of care, arguing that a long-term approach reveals similar if not indistinguishable dynamics of both mobility and cost accumulation for patients included and excluded from government support. Catastrophic cost accumulation is found in both groups. In engaging the growing conversation among oncologists and medical researchers on the topic of "financial toxicity," the chapter suggests the need for new frameworks for conceptualizing long-term financial burdens in contexts where cancer is not the sole or central but one of

[22] Additionally, in 2012 I conducted interviews with this patient population for my MA thesis at the American University of Beirut.

several factors driving financial ruin. The combined forces of illness, war, and the destruction of livelihoods converge in draining kinship networks of resources.

Importantly, the data sets in chapters 1 and 2 are by no means entirely separate. Many interviews with patients traveling or displaced to northern Kurdish hospitals (chapter 1) report simultaneous cross border trajectories to Lebanon, and many interviews with patients in Beirut (chapter 2) reveal a simultaneous reliance on north-bound trajectories of care to the Kurdish provinces of Iraq. This convergence indicates that one can view and analyze different but overlapping contours of the broader geography of oncology from the vantage point of any of its various nodes.

While the notion of a *journey* brings a certain unity to the dissertation, there is simultaneously a subtle distinction in method, style, and approach between the first part of the dissertation and the second. Part I has sought to retain recognizability within the methodological and writing conventions of oncologists and health practitioners. I break up my materials into 'cases' and engage largely with medical and public health scholarship. The genesis of this approach came in an early encounter with a senior Iraqi oncologist who reviewed my research methodology and found it to be "very basic and lacking definition." In the end we developed an interview approach that satisfied his needs and mine.

Part II of the dissertation (chapters 3 and 4) turns to a single ethnographic case study drawn from the experience of residing and traveling with a patient and his family over the course of four years. The patient, a farmer in his 40s from Salahadin who I will call Abu Samir, was initially enrolled in the study as an interviewee in Beirut. Soon after his initial Beirut-based interviews in 2014, he returned home for respite only to be

displaced from Salahadin to Erbil. In displacement, he underwent treatments in Beirut as well as Erbil — bridging the two emerging oncology hubs under examination in the dissertation together. Between 2015 and 2017 I resided with the family intermittently for periods totaling approximately 7 months in their displaced Erbil home, and I accompanied the patient across borders for treatment. Whereas chapters 1 and 2 arise out of interviews and ethnographic work within and between oncology hospitals, chapters 3 and 4 takes us into the domestic, mundane spaces to which those patients return. A broader set of voices beyond the patient – those of brothers, uncles, wives and cousins – emerge in shaping and defining the cancer journey, not always for the better.

Chapter 3 "Mobilizing Resources Amidst Displacement" brings the question of financial toxicity into a specific network of kin and neighbors struggling to amass resources for a cancer patient amidst displacement. Examining three different periods in Abu Samir's journey, I show how the kinship network moves through different justifications for either granting or withholding resources towards his treatments in Beirut. Evolving dynamics of sectarian tension and violence are drawn into these justifications, providing kinsmen language to either facilitate or obstruct Abu Samir's capacity to mobilize support for treatment. Amidst displacement people do not have sufficient access to context to forecast or understand these logics in advance, and thus they require careful ethnographic elaboration in the sites and encounters in which such justifications arise.

Chapter 4 "The Companions: Temporalities of Illness Accompaniment" explores Abu Samir's journey for treatment through the labors of his "companion" (*murafiq*), a nephew appointed to serve as his partner in trips across Iraqi provinces and international

borders. This chapter explores how the temporality of the *murafiq* role shifts when long-term and repeated travel across borders removes the domestic point of return. Yet, as I will show, the old boundary is reanimated in a different way in Beirut: Daily male sociality among fellow *murafiqeen* preserves spaces of 'non-work' and respite from their charges. This 'non-work' is justified as a time or space when fellow *murafiqeen* can accompany and care for one another as men. This care, which involves a temporary forgetting of the toils of the *murafiq* role, simultaneously involves a shared remembering of male vulnerability to violence amidst war. As travel brings the wounds of war into shared social spaces (*See* Dewachi 2015), Iraqi *murafiqeen* in Beirut respond by caring for their patients *and* one another, forming bonds with fellow companions. The relations among the companions also generate spaces of care and sociality for their charges. One important contribution of this chapter is to show how therapeutic geographies are not exclusively or necessarily oriented around the 'care' offered by biomedicine. We cannot imagine trajectories across borders within a solely medicalized frame. Relations beyond the clinic are crucial in providing care, support, knowledge and healing.

Thus, while Part II involves an in-depth study of a single case, Abu Samir's story simultaneously draws into its unfolding the journeys and accounts of multiple patients and their networks of support. A *journey* for care not only cuts across and brings together different categories of movement one might imagine as distinct (e.g., refugee healthcare vs. medical travel), but also encompasses a wide array of institutional and social relations drawn together through movement. This approach draws inspiration from anthropological studies of Muslim travel and pilgrimage (Eickelman & Piscatori 1990, Delany 1990),

which have emphasized the social formations and encounters arising through movement alongside a whole host of others.

As we follow the journeys of Abu Samir and others, various memories and stories of war will be drawn into relations of care. For instance, in chapter 4 we will see how Abu Samir's "companion" (*murafiq*) drives slowly to the hospital, in part due to a recognition that Abu Samir attributes the onset of his cancer to the long-term effects of a nasal injury he incurred on a roadway during the Gulf War of 1990. Readers familiar with Iraq may note with surprise that this particular etiological formulation is related to war but not war-related toxicity in the form of depleted uranium (DU). No Iraqi cancer patient would have been alarmed: Abu Samir is from rural central Iraq — not an area associated with the high intensity urban shelling and bombing of the 1991 and 2003 wars. Much ink has been spilt on the question of depleted uranium (DU) and cancer. During the 1991 aerial campaign over Iraq, the US utilized approximately 340 tons of missiles containing depleted uranium (DU) (Peterson 2000). Following the war, the Iraqi government's case before the world was twofold: The Coalition had caused cancer rates to rise through toxin-releasing bombs, while also destroying the means of treatment through sanctions. [23] Cancer became symbolic of the mass death and institutional decline associated with the decade-long sanctions following the 1991 Gulf War. The international community paid

[23] Iraqi Health Under Secretary Shawqi Sabri Murcos stated at a 1998 conference in Baghdad: "The use of depleted uranium (DU) has caused irreparable damage to Iraq's people and its environment…Our surveys show a dramatic increase in cases of leukemia, especially among children in areas of southern Iraq bombed by the allies" (Ciment 1998). During the 1990s, the Iraqi government's Committee for Pollution Impact by Aggressive Bombing disseminated research on rising cancer rates in relation to DU. At a 1999 conference among concerned British policy makers and activists in London, representatives of the Committee reported that rates of congenital abnormalities and cancer had doubled since the 1991 Gulf war (Aitken 1999).

notice with significant journalistic reporting and formal responses from the WHO, the Pentagon, and the UK's Royal Society (Kirby 2003).

Discourses around war-related environmental changes remain in circulation almost 20 years later in international and occasionally Iraqi journalism, but Abu Samir's story suggests that these discourses have always and continue to be layered with meanings and associations related to diverse iterations and experiences of war. DU cannot exhaust the discussion of cancer in Iraq.[24] Iraqi cancer patients participating in this study variously reported connections between cancer and multiple forms of war-related causation, including depleted uranium, residue from car bombs, low-grade impure food issued during the deprivations of UN sanctions, etc. These toxins overlap with powerful emotions of grief and loss associated with the onset of serious illnesses such as cancer. The significant international fixation with the impact of DU is indicative of a tendency in the all too common journalistic approach to talking about Iraq in many American outlets: Headline-worthy, generalized associations and categories — arising out of the interventionist mode of American-Anglo engagement with Iraq — stand in for a more intricate exploration of Iraqis' varied experiences of the wars of the past three decades.[25]

Accordingly, the analysis of this dissertation will go beyond a generalized analysis of collective phenomena of illness and mobility, instead exploring the singular trajectories and experiences of different families and individuals. In doing so I build upon recent anthropological studies which have explored how people in movement imagine

[24] A truly robust approach to the problem of cancer-generating toxins in Iraq would require partnerships between anthropologists, epidemiologists, and environmental scientists in the manner described by Manderson (2015), and would investigate a much broader reach of toxins than depleted uranium.

[25] To avoid this tendency one can read the important journalism of Jane Arraf, Tamer el Gobashy, Raya Jalabi, and I am sure others I have missed.

and project themselves by remaining attentive to their varied vocabularies and concerns, which may include references not only to physical movement across borders but also existential movements of warding off or acknowledging death (Pandolfo 2007, Hage 2009). While such an approach may produce research results that appear to be of marginal use to questions of policy (Bakewell 2008), I will reflect upon how the anthropological commitment to the study of the complex layers of lived experience can provide an important perspective within debates among doctors, healthcare officials, and NGOs working to improve the quality and access to healthcare under long-term conditions of war, and in other contexts where mobility is central to the pursuit of care.

CHAPTER ONE

Journeys to the Kurdish North: Rethinking Therapeutic Geographies

In December of 2016, the battle over Mosul compelled hundreds of cancer patients to make the arduous passage to Erbil where they could continue treatment at Nanakali Cancer Hospital. Every hour, a new World Health Organization (WHO) or International Red Crescent (IRC) ambulance arrived to the hospital's driveway from Mosul caked with mud. One ambulance driver complained to me that the roads had not been maintained for over two years under *daesh*, and his vehicle's axle was suffering as a result. Mosul patients desiring passage into Erbil had no choice but to take an ambulance. Otherwise they risked being turned back at the checkpoint entering the Kurdish Regional Government (KRG) because residents of *daesh*-controlled areas were subject to heightened security checks. These 2016 arrivals from Mosul to Nanakali Cancer Hospital found themselves amidst a whole host of previously "displaced persons" (*naziheen*) in the hallways and waiting rooms — people who had since 2014 fled from Anbar, Salahadin, Diyala and other areas affected not only by *daesh* violence but also by the militias countering *daesh.* Successive waves of displacement converged in a common treatment center.

In addition to the displaced, residents of southern provinces such as Najaf could be found in the waiting rooms. They considered the level of care in Erbil to be better than Baghdad, particularly for hematology. Nanakali was considered among the top referral centers in the country. Local Kurdish patients still held a slight majority of the seats in the waiting room, but the proportion was no longer clearly in their favor — a contentious

issue among both hospital staff and broader Kurdish politics. The major cities of Erbil and Sulaymaniyah invested heavily in oncology since 2003 in order to serve a Kurdish population that previously lacked oncology services. But recently the cancer centers of the Kurdish north have become hubs for a mix of displaced persons, travelers, and care-seekers from across the country. This chapter charts the journeys of such patients to the Kurdish north. I focus specifically on the journeys of the "displaced" (*naziheen*) in order to raise questions about scholarly depictions of the mobilities of conflict-affected populations.

Data is drawn from interviews with patients and their family members at three hospitals located in the northern provinces — Nanakali Cancer Hospital (Erbil), Hiwa Cancer Hospital (Sulaymaniyah), and Kirkuk Cancer Center (Kirkuk). While Kirkuk legally falls outside the Kurdish Regional Government (KRG), its placement on the geographic and political border between federal and Kurdish Iraq has rendered it a way-station in patients' journeys moving northward to access KRG hospitals. The goal of the interviews at the three hospitals was to map out patients' routes of treatment across an emerging geography of oncology, a geography in which northern Iraq has become a particularly important node. It is a node and *not* an undisputed center or end point. Many of the Mosul arrivals to both Nanakali Hospital in Erbil and Hiwa Hospital in Sulaymaniyah discussed the possibility of Beirut, Istanbul, and Baghdad as they faced the long wait times and warnings from staff of possible shortages.

During one of my first days at Hiwa Hospital in Sulaymaniyah, an Arabic-speaking man dressed in traditional Kurdish garb joined me on a bench, greeting me in an Arabic dialect that sounded much like the southern Salahadin accent to which I had

become familiar during my months of residence with a displaced cancer patient from the same area (*See* chapters 3 & 4). "I am Salam," the man said to me. "The father of whom (*abu minn?)*," I asked in the customary pleasantry. "I'm Abu Abdullah," he replied. Abu Abdullah was the "sheikh" of a small community of farmers along the Tigris in southern Salahadin. Now displaced to Sulaymaniyah, he was accompanying his mother, who was suffering from advanced small bowel cancer. He focused on potential treatment sites for his mother:

> "I'm always asking people, and I'll ask you, what do you think of Beirut? Of Turkey? By God (*wallah*), the precision of the medicine is more precise (*daqeeq*) there. I've heard that because of the budget crisis [in the Kurdish region of Iraq], they will kick the displaced out of the hospital in Sulaymaniyah. The treatment is good here, better than other places in Iraq, but maybe they'll say, get out!"

This was not the first time Abu Abdullah had faced questions arising from a geography of care marked by multiple contingencies. His mother developed a set of painful growths in 2013. The doctor in rural Salahadin diagnosed her with an "infection." They intended to travel to Kirkuk or Erbil to see doctors with higher pedigrees, but they were displaced in 2014 around the time when *daesh* arose and advanced towards their hometown of Yathrib. "I had a brother, he was killed by *daesh,* not in Yathrib but nearby*."* At this I asked if any other force had been involved in forcing them to leave their homes. He added: "Yes, yes, I had one brother killed by *daesh* and another killed by the militias."

The "militias" mentioned here are the *hashd sha'abi* (Popular Mobilization Forces, often abbreviated to PMF or 'the *hashd'*), the coalition of militias that coalesced in 2014 to counter *daesh.* The *hashd sha'abi* arose partly in response to a fatwa by the

Shia leader Ayatollah Sistani to protect the country from the *daesh*, eventually receiving support and official recognition from the federal government. While *hashd* units in certain areas of the country were eventually composed of a range of minority groups and even Sunni Arabs, the displaced Sunni Arabs and Kurds often described the *hashd* as a force that threatened their essential security on sectarian grounds. It is important to note that Abu Abdullah does not mention *hashd* violence without my indicating that it was permissible to do so. He was cautious to avoid being misread as a *daesh* sympathizer and thus emphasized *daesh* violence over and above that of state-backed armed groups.

Abu Abdullah continued: They were forced to flee north. They drove through checkpoints several hours north to a refugee camp in Kalar, a small town situated at the southern tip of Sulaymaniyah province.

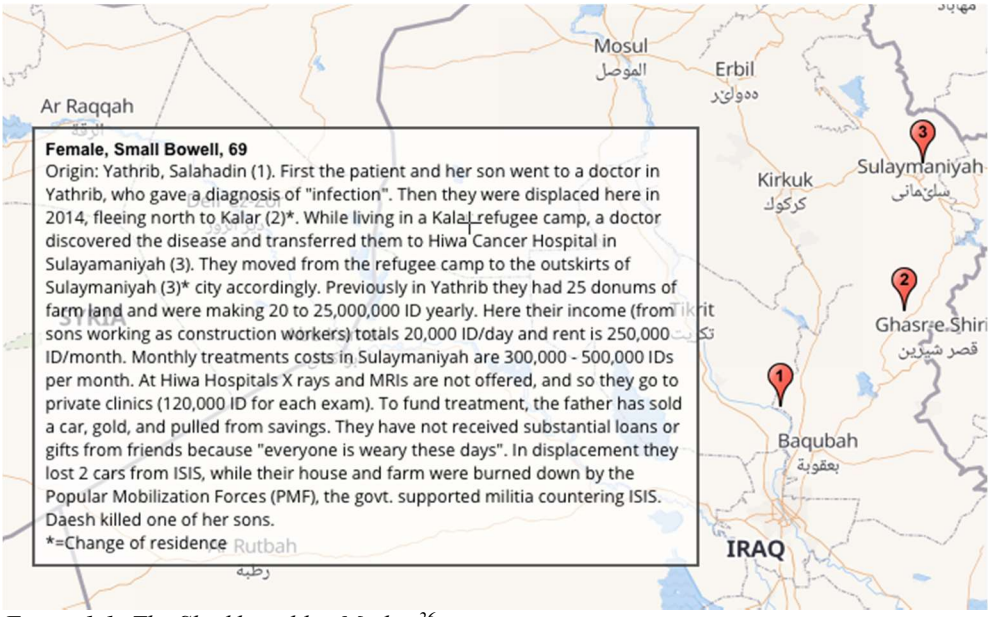

Figure 1.1: The Sheikh and his Mother[26]

[26] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

The fact that they were able to cross into Kurdish Sulaymaniyah by land was a testament to the extent of his network as a sheikh. "*Wallah* in my role I've gotta know people." While living in a Kalar refugee camp, a doctor discovered the disease and transferred them to Hiwa Hospital in Sulaymaniyah city. They have undergone treatments at Hiwa ever since.

In our interview the sheikh mostly focused on rattling off financial calculations. Costs quickly accrued in displacement. Previously in Salahadin, Abu Abdullah had 25 donums of farm land and was making 25,000,000 Iraqi Dinars (IDs) yearly.[27] In Sulaymaniyah, their income (from sons working as construction workers) totals 20,000 IDs/day and rent is 250,000 ID/month.[28] Monthly treatment costs in Sulaymaniyah are 300,000 – 500,000 IDs per month. At Hiwa Hospitals X-rays and MRIs are not offered, and so they go to private clinics (120,000 IDs for each exam). To fund treatments not offered publicly, Abu Abdullah has sold a car, gold, and pulled from savings. Only certain agricultural kinship structures can operate effectively as independent economic units in displacement. In Salahadin, Abu Abdullah had never relied exclusively on his children and wives for farming labor. He typically hired day laborers to carry out agricultural tasks requiring heavy labor. Consequently, in displacement they were not equipped in terms of manpower or skill to operate a plot as a tenant farming unit.[29] Their only option was employment as day laborers.

In departing, he made a number of statements simultaneously expressing concern about his debts and his mother's distress. The loss of his brother as well as their home in

[27] 25,000,000 Iraqi Dinars (IDs) = $20,990 United States Dollars (USD)
[28] 20,000 IDs = $ USD; 250,000 IDS = $209 USD
[29] See chapter 3 for an extensive discussion of household economics under displacement, and the impact on raising resources for cancer.

the flight from Salahadin had generated *qahr* across the kinship network, an emotion associated with both sorrow and anger. (See chapter 2 for an extended discussion of *qahr*.) "This disease, it's all from *qahr,"* he reflected. *Qahr* was understood to generate and exacerbate cancer. Without delving into further details, Abu Abdullah had to bid permission to step aside and attend to his mother. Our initial encounter came to a close.

*

Throughout the dissertation and particularly in Part I (chapters 1 and 2), descriptions of immensely complex violent events largely rely on the articulations of individuals. My presentation of these events in the case studies makes no claim to reveal 'what happened' (Das 2007: 75), but rather how they are articulated within accounts of illness journeys. I begin with Abu Abdullah's example in order to highlight the multiple intersections between violence, mobility, displacement, and political economy in the unfolding of a cancer journey. A geography of care is continuously made and remade as Iraqis negotiate such relations and move according to their evaluations of the shifting context before them. The numerous contingencies bearing upon the sheikh's calculations meant that the path forward remained unclear. The sheikh and his mother ultimately did not seek care in another province or cross border city after arriving to Sulaymaniyah. And yet the possibility of doing so remained in question until his mother's last breath. He sent his mother's reports to Beirut, Delhi, Istanbul and other high-tech hubs for remote consultations. Abu Abdullah's eye scanned a field of interconnected sites across multiple countries. Perhaps paradoxically, two sites removed from his field of vision were the strong oncology centers located in the Kurdish capital of Erbil and the federal capital of Baghdad. The Erbil checkpoint was too "restrictive." And travel to Baghdad was

"impossible" due to the presence of militias. His perception of proximity did not conform to physical distance or national borders.

This chapter will chart several such cases, relying on a mix of interviews as well as accompaniment of patients across cities and borders. As discussed in the Introduction,[30] recently Parkinson and Behrouzan (2015) have critiqued Dewachi et al. (2014) for relying too heavily on "macro-level" analysis of population movements. They stress the importance of analyzing therapeutic geographies from the "bottom up" or "micro" level — i.e., drawing upon the everyday lives and experiences of people navigating these geographies. This chapter takes up this call for a turn to lived experience of therapeutic geographies while stressing a shift in the framing of scale. Instead of assigning "lived experience" to the scalar domain of the "micro," I will posit that we arrive at a phenomenological sense of scale only through attempts to document the spatial and social relations described and experienced by those inhabiting and moving across a world. This methodological orientation is particularly important in contexts of war where temporal and spatial frames are highly indeterminate and unstable (Al Mohammad 2012; Lubkemann and Hoffman 2005). We will have no capacity to grasp cancer patients' perceptions of spatial and temporal relations without entering into the world of relationships in which their sense of a geography of care emerges.

Prior to the case presentation and analysis, the aim of the forthcoming sections is to arrive at an understanding of how the spatialization of healthcare seeking has been imagined under conditions of war and displacement. In exploring this question, we will pay particular attention to the figure of the so-called internally displaced person (IDP),

[30] See the Introduction for the previous discussion of scale.

not only because the "displaced" (*naziheen*) make up the bulk of the study's research subjects but also because their healthcare mobilities are imagined in ways that illuminate broader assumptions around scale and the spatialization of healthcare in conflict. First let us examine the figure of the *naziheen* in the context of Iraqi and specifically the KRG healthcare institutions. Second we will engage the scholarly literature on the care-seeking mobilities of the displaced.

Displacements of Patients and Doctors in Iraq

This surge of IDPs entering the KRG following the rise of *daesh* in 2014 has exacerbated the conflict over healthcare budgets between the Baghdad-based federal Ministry of Health and the Erbil-based KRG Ministry of Health. The KRG Health Ministry, which had already witnessed a decline in funding from Baghdad due to the broader budgetary tensions between Baghdad and Erbil,[31] has demanded additional funds from Baghdad to cover for IDPs. (The relationship between the federal Ministry of Health and the Kurdish Ministry of Health is essentially reduced to budgetary and pharmaceutical transfers. Federal authorities allocate money and pharmaceuticals to the KRG provinces; however, they leave administration over Erbil, Dohuk and Sulaymaniyah pubic hospitals to the KRG Ministry of Health.) With Nanakali and other KRG hospitals reporting a crushing load of non-resident patients between 2014 and 2016 and demanding commiserate federal compensation, the Baghdad Ministry of Health sent a representation

[31] See Butler (2015) for a discussion of the Erbil-Baghdad budget crisis. In short, the KRG's moves to make oil deals independently of Baghdad generated a constitutional crisis, and Baghdad responded by delaying or reducing payment to the KRG's budget, which is legally set at 17% of the overall Iraqi national budget. This cut coincided with a 2014 plunge in oil prices, further diminishing both the federal and KRG budgets.

to Nanakali to tally up the non-Erbil patients. I visited the official after a year on the job. He told me, "By God there are so many displaced, so many people just coming up here because they don't trust the medication in Baghdad, but most don't even come register with me…."[32] He had been given a small office tucked away to the side of the section for hormonal therapy. He recorded new admissions from the federal provinces:

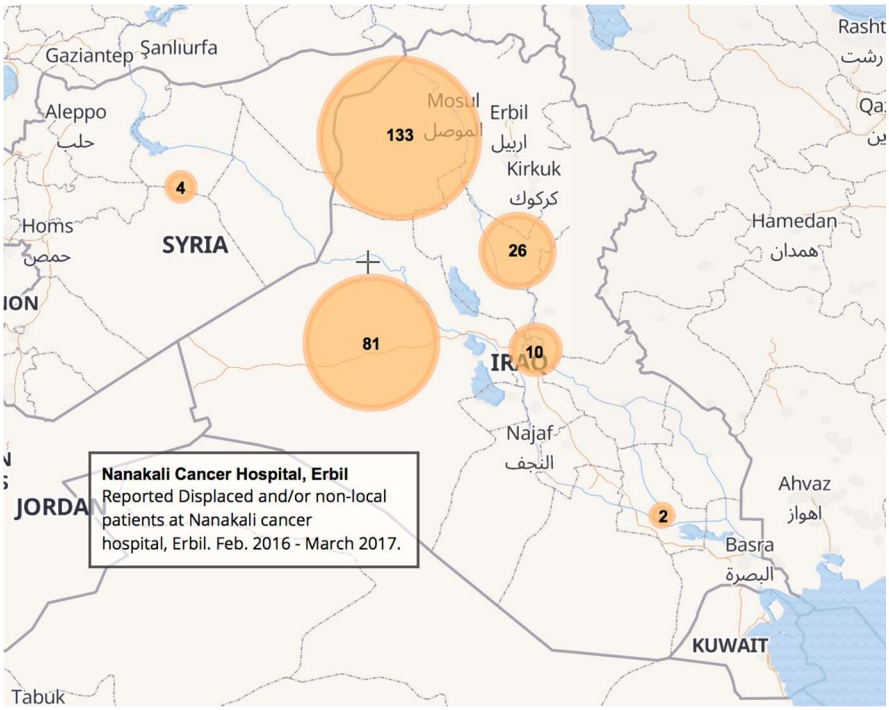

Figure 1.2: Federal government data on IDP cancer patients in Erbil [33]

The non-resident cases he had recorded were as follows: 133 from Mosul, 81 from Anbar, 10 from Baghdad, 26 from Salahadin, and 2 from southern provinces. Most displaced patients and travelers from federal provinces did not have much interest in visiting him once they realized his office had little help to offer.

[32] Interview between the author and Baghdad representative to Nanakali Cancer Hospital, March 2017.
[33] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

The most recent wave of migrations following the rise of *daesh* in 2014 has disproportionately communities hailing from Anbar, Salahadin, and Mosul. Many of these communities found themselves in a double bind between living under *daesh* or fleeing to areas controlled by the government-backed Popular Mobilization Forces (PMF). In this fraught political context, the provinces under the semi-autonomous Kurdish Regional Government's (KRG) direct control (Dohuk, Sulaymaniyah, Erbil) or indirect control (Kirkuk) presented a relatively secure context for resettlement. By 2015, 426,966 IDPs were reported in Dohuk (as compared to 32,651 in 2008), 161,724 in Sulaymaniyah (a compared to 65,891 in 2008), 401,280 in Kirkuk (as compared to 47,466 in 2008), and 284,310 in Erbil (as compared to 96,581 in 2008). Accordingly, Nanakali Hospital in Erbil and Hiwa Hospital in Sulaymaniyah have seen huge surges in patients.

Many of the displaced cancer patients participating in this study expressed a measure of relief that they had manage to relocate to a region where they could, for the first time, access quality care within relative proximity to their site of residence. However, echoing the sheikh's sentiments mentioned at the outset of the chapter, many understand this proximity as fragile. They fear eventual expulsion from the Kurdish hospital system, and not without reason. As IDPs increased during the 2016 Mosul battle, Nanakali Hospital in Erbil explicitly instituted a policy of triage towards non-resident new admissions, offering administration of drugs to but not their provision. Moreover, KRG healthcare authorities have consistently employed a discourse towards IDPs that emphasizes their detrimental presence in terms of the cost of care. At an October 2016 American Society of Clinical Oncology conference in Erbil, several officials lamented

the "burden" of IDPs on the Kurdish public oncology apparatus (Skelton et al. 2017). [34] The irony of this discourse around the "burden" displacement on the KRG oncology system is that the KRG has relied heavily on displaced doctors from the rest of Iraq.

At the hospital level, oncologists at Nanakali Cancer Hospital in Erbil and Hiwa Cancer Hospital in Sulaymaniyah have made repeated overtures for funding relief not only to the federal and KRG ministries but also to NGOs, international donors, UN agencies, etc. Yet, as Livingston (2012) notes, cancer has been largely invisible within the development telos of global health, and Iraq is no exception. Countries in the "developing" world are conceptualized as existing in a simplified biological state – under the scourge of infectious disease and not the chronic diseases associated with middle class lifestyles. One of the oncologists at Nanakali Cancer Hospital told me, "The UN people, they come talk to us, and we talk to them about the displaced, but in the end no funding comes, only to primary care." A strategy of some KRG oncologists and administrators has been to maintain close ties with cancer centers throughout Iraq's 18 provinces: When there are surpluses in public supply of oncology pharmaceuticals in any province, they send couriers to retrieve them. Periods of diplomatic tension between KRG – federal agencies do not necessarily map onto doctor networks spanning the country. KRG oncologists I interviewed at Nanakali insisted that the need for triage practices towards Arab non-residents was an entirely new phenomenon resulting from

[34] Cetorelli et al. (2017) indicated that IDPs residing within camps in the Kurdish Regional Government reported suitable rates of primary health care accessibility both within the camp as well as private/public options, fairing markedly better IDPs in Baghdad, Karbala, and Kirkuk (Lafta et al. 2016). However, the politics of oncology in the KRG are distinct due to the high costs involved.

intense budgetary pressure, and would cease once funding returned. Oncologists at Hiwa Hospital negated biased triage towards non-residents.

The perspective of doctors will not, however, form the core of the analysis in the cases to follow. (We will return briefly to the voices of doctors following the presentation of the cases). Multiple actors are involved in facilitating or obstructing access to treatment, most notably security actors manning roads and checkpoints. Understanding the cancer journeys of conflict-affected populations converging upon the Kurdish north requires, I argue, tracking their movements and experiences across the range of sites constituting a pathway of care.

Literature Review: Spatializing Therapeutic Mobility under War

Conceptually the adoption of such a methodology will involve a departure from paradigmatic socio-spatial categories employed in refugee studies and public health. Scholarly conversations around refugee and IDP healthcare have, to date, largely imagined the displaced (both internally and across borders) as seeking care within a particular urban environment or camp – i.e., the circumscribed "host community." They are not imagined as agents of wide ranging-mobilities in relation to healthcare. Let us explore this matter in the context of refugee studies and public health.

Refugee Studies and Global Health

First it is important to note a contradiction between the depiction of displacement as multi-directional and the depiction of the care-seeking mobilities under displacement as spatially confined. Researchers in refugee studies such as Monsutti (2010) and Chatty

& Mansour (2011) have described displacement as a multi-directional, multi-nodal phenomenon. Against the earlier understanding of migration as a linear process beginning with uprooting from the place of origin and ending with integration into a host country or community, these studies emphasize multiple migrations and a variety of social relations across borders (Monsutti 2010). Such conceptual frameworks then appear in public health scholarship. Writing in the journal *Global Public Health*, Mowafi's (2011) depiction of displacement includes multiple overlapping circumstances for movement across borders such as violence, labor, trafficking, temporary visits, etc. Mowafi's understanding of displacement as multi-layered speaks to the longstanding inter-disciplinary conversation between refugee studies and public health. Mowafi's main citations are from refugee studies journals.

The weakness of Mowafi's approach lies in the failure to merge the complex picture of multiple displacement mobilities with a correspondingly complex spatial analysis of healthcare access. The discussion of healthcare needs and access reverts to a linear model of displacement – i.e., a move from origins to "host countries." He notes how "case studies can form the basis for analysis of existing *host country* policies regarding displaced populations and provide guidance for health policy reform to meet the needs of both displaced populations and their *host communities*" (Mowafi 2011: 483, *emphasis added*). Mowafi's framing of displaced persons' healthcare seeking as situated within *host* countries and *host* communities retrenches a picture of mobility whereby refugees and/or IDPs move from one country or one community to another, and then they seek out treatments and other crucial services within that locality. Mowafi continually mentions the "burden" of "providing services to the displaced" within "host

communities" (Mowafi 2011: 482). Research on IDPs and refugees have largely treated them as spatially limited actors in terms of healthcare access.[35]

Geographic Approaches

If IDPs with cancer are to emerge as robustly mobile actors, what methodology can one employ to study their movements in pursuit of care? Geographers have experimented with a number of tools and frameworks for understanding the geographic dimensions of accessibility to health care. The most basic of these models involves a measure of travel time and distance from point of origin (i.e., the home) and the point of care.[36] Such measures are particularly attractive to public health professionals who seek out simple and implementable models for conceptualizing interventions. More complex models have combined travel time and distance with the supply/demand of healthcare services across a given region. The confluence of time, distance, and supply/demand more accurately reveals the exposure of individuals to inaccessibility. But Neutens (2015) has noted the limitations of combining such variables, as they still tend to capture static pictures of mobility, thereby ignoring "the uncertainty about the area, timing and duration in which individuals are exposed to contextual (i.e. social and environmental) influences

[35] When healthcare mobilities of displaced persons are mentioned in public health studies on Iraq, they are referenced only in passing and do not receive sustained attention. For instance a recent study by Lafta et al. (2016) on IDPs in Iraq notes the fact that healthcare "services were accessible on foot to 280 (23.0%) families while the remaining 77% of families indicated that a car or other transport was needed to access these services" (Lafta et al. 2016). Unfortunately, we do not see an exploration of these movements by foot or car and how they map across a geography of care.

[36] For example Zhang et al. (2018) track the travel time, travel distance, and travel modes of transport (walk, car, bus, van) between places of residence and Harlem screening/treatment facilities for the elderly.

thought of to affect their health behavior" (Neutens 2015: 22). Accessibility studies tend to make measurements at the level of administrative districts, and this scalar unit tends to obfuscate "micro-level accessibility problems of social groups and neighborhoods" as well as "important sources of social inequality including mobility resources" (Neutens 2015: 22). The source of the problem lies in the manner of data aggregation in the study of geography: "Given that accessibility to health care has hitherto been measured in an aggregate and a-temporal manner, the unequal distributional effects of health care provision across various social groups of the population have never been properly studied" (2015:23). Neuten's suggested solution is to develop models that better assess "individual travel and healthcare behavior" (2015: 26). To this end, Neutens proposes that geographers utilize existing data sets and employ "more powerful geocomputational tools in order to obtain a more nuanced picture of how accessibility varies across space-time" (2015: 26).

Health geographers — self-described post structuralists — agree with Neuten's provocation but not his answer. Instead of improving upon aggregate data tools, they have attempted to push the study of place in the direction of approaches that incorporate shifting scales, temporalities, and social formations through participatory methodologies. For health geographers, space is no longer understood as a 'container' but as arising in and through relationships between heterogeneous actors. In order to capture these open-ended notions of space, health geographers have embraced lived experience and participatory methods (Prior et al. 2018). Yet this health geography literature has yet to deal extensively with questions around health care mobility under conditions of war and displacement. For this reason, I have emphasized the importance of the Parkinson and

Behrouzan (2015) study in that it has offered a substantial attempt at accomplishing just that, as they apply participatory methods to the study of Syrian refugees' engagement with a shifting geography of care in Beirut. Yet, in keeping with trends in refugee studies around the centrality of the "urban refugee," [37] the study retains the spatial locus of the city and a limited temporal frame. Expanding upon this approach spatially and temporally, one aim of this dissertation is to experiment with methods that allow the tracking of illness trajectories across widely disparate sites and over the long course of the illness. Over multiple years a single journey for cancer care may include trajectories that appear to align with the typical spatial coordinates of refugee healthcare (proximity to new site of residence) while other portions of the journey appear to align with the spatial coordinates of medical travel (international sites of destination). Multiple cities, regions, and states are folded into a singular experience of cancer care.

*

Below I present several in-depth case studies of cancer patients undergoing treatments in one of three northern Iraqi hospitals. The 5 cases are drawn from a broader data set of cases. In total, 20 case studies were conducted at Kirkuk Cancer Center (Kirkuk); 28 at Nanakali Cancer Hospital (Erbil); 44 at Hiwa Cancer Hospital (Sulaymaniyah) between 2016 and 2017. The cases presented below have been selected to reflect patterns of mobility found in the broader set. The cases are divided into two groups by methodology. In the first group (cases 1, 2, and 3), I formulated the journey of the patient via in depth hospital interviews within the clinical setting and subsequent

[37] The turn to the study of the "urban refugee" is largely an outgrowth of the Iraq War, as scholars noted that Iraqis generally avoided camps and instead opted for urban lives in Amman, Damascus, etc. (Chatelard 2010).

follow up whenever possible. In the second (cases 4 & 5), I formulated the journey of the patient through a mix of interviews and accompaniment across provinces and borders.

Hospital-based Interviews

Case 1: Mr. Bilal

Before interviewing patients journeying to Sulaymaniyah for treatment, I took 10 interviews with local Kurdish patients in order to understand how they had experienced a geography of oncology that had, since 2003, converged around them. Let us examine one such case. Mr. Bilal is an 83 year old prostate cancer patient from Sulaymaniyah. He spoke with enormous energy in the highly proficient Arabic of the older Kurdish males who solidified the language serving in the army alongside Iraqis from across the country. I asked him to talk about his disease and the "journey" (*rihla*) of treatment. He began confidently: "My brother Mr. Mac, the disease surfaced in 1995..." He explained that many Kurds were coming down with the disease at that time due to toxins of the *Anfal* campaign combined with the decline in food quality during the "blockade" (*hisar*), i.e., UN Sanctions. He wanted me to understand that he recognized the expansiveness of this problem across Iraq beyond Kurdistan: "Mr. Mac, it was also the rest of Iraq. Basra, Najaf, even Baghdad. No one had proper food. Hospitals were falling apart. The disease spread everywhere." This acknowledgement of a shared history of war linking the Kurdish region to the rest of Iraq would be reflected in the subsequent account of his mobilities across Iraq in pursuit of treatment.

He explained that, as no formal cancer apparatus existed in the Kurdish north in 1995, he underwent surgery and treatment in Baghdad, which was successful and

furnished the ground for 15 years of "no disease" (*al maradh mako*). When the disease emerged again in 2010, he underwent treatments exclusively in Sulaymaniyah at the newly constructed public center. "The hospital is just 2 kilometers from my house!" He noted his gratitude for the new cancer center, but also a sense of loss at the perceived decline of Baghdad's medical apparatus and the unraveling of the social fabric: "In Baghdad I had many relatives, all Kurds. Baghdad Medical City, it was truly a city! The hospital was magnificent, even though Saddam was bad for the Kurds. But all the doctors left."

Figure 1.3: Case 1 [38]

Mr. Bilal's case provides a window into the geographical redistribution of the oncology system between the 1990s and the post-2003 era, and the dramatically shifting fortunes of the Kurdish population in terms of enjoying proximity to treatment. The first iteration of the disease in 1995 forced Mr. Bilal to travel outside Sulaymaniyah southward to Baghdad. Under the political environment of the time, this was no small

[38] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

feat. Following the Gulf War of 1991, the US-led Coalition imposed a no fly zone over the Kurdish provinces and effectively established the political autonomy of the region. As before 1991, residents of the Kurdish provinces in theory had three oncology options — they could travel to Mosul, Baghdad, or abroad — but the hardened political divide between the newly enshrined semi-autonomous Kurdistan and the federally controlled provinces made matters more complex. Many Kurds I interviewed spoke of the 1990s as a time of absolute therapeutic dead ends. How could they travel to federally controlled Baghdad or Mosul following the Anfal campaign of the late 1980s and the Kurdish uprising of 1991? But these sentiments were not shared by all Kurds. Other Kurds, like Mr. Bilal, enjoyed deep historical ties with Baghdad and extensive kinship networks residing in the capital city. Mr. Bilal spoke fondly of his Kurdish Baghdad relatives, most of whom now reside in either Erbil or Sulaymaniyah. During the 1990s he was able to capitalize on these connections in order to secure a spot in Baghdad Medical City. When his disease returned in 2010, he had no reason to travel south. In his view the Baghdad he once knew was no more, and Sulaymaniyah had gone from having no oncology to having the highest-rated center in the country. The public cancer system in the Kurdish Region was founded in the years following the US-led invasion of 2003, a period in which the Kurdish Regional Government enjoyed relative stability under US protection of their political autonomy. The geography of oncology shifted to his doorstep. Mr. Bilal had not yet seriously contemplated a cross-border journey to Beirut, Istanbul, or another regional city. His daughter informed me that his age would not allow such a thing.

As we parted ways, Mr. Bilal scanned across the waiting room. It was still the early morning and the room was packed. Some patients spoke Kurdish, others Arabic,

and still others Turkman. This juxtaposition prompted a brief moment of reflection: "By God Mr. Mac, this reminds me of Baghdad before the *soqood* (fall of the regime). Everyone from across the provinces in Baghdad Medical City. Now it's us who has people from all over, but mostly these *naziheen* (displaced), some Kurdish, some Arabs, it's a shame. How can a man be well and he knows his brother is in trouble?" Again Mr. Bilal expressed a historical consciousness regarding the shifting geography of care and affliction. Sulaymaniyah had, in his view, become like Baghdad of old. Yet the presence of the *naziheen* cast a sorrowful shadow over this transformation. Such expressions of warmth for the plight of the displaced were not uncommon among the local patients. As I turned my attention towards interviewing the *naziheen*, I continued to receive tips and support from Mr. Bilal and other Kurds who found importance in the project.

Case 2: Um Hassan and Hassan

Um Hassan is a 50 year-old female with breast cancer from the city of Ramadi in Anbar province. I conducted an interview with her eldest son Hassan at Hiwa Hospital in Sulaymaniyah, Iraq in November of 2016. Hassan was clasping and rubbing his hands together, sweating even though the room was cold. Just 24 hours earlier, he and his mother had been displaced from their temporary home in Kirkuk. They had resided in Kirkuk for two years since their first displacement from Anbar in 2014. They made bi-monthly trips across the Kirkuk-Sulaymaniyah checkpoint for treatment. But now they were uncertain of what lay ahead in terms of both residence and treatment. In response to a *daesh* attack in Kirkuk days earlier, a mix of local citizens and *peshmerga* units expelled large swaths of displaced Arab families from the city, forcing Um Hassan and

Hassan to separate from the rest of their family and flee to Sulaymaniyah in order that she could continue care. For the time being, they were temporarily residing in a $30/night hotel in Sulaymaniyah, and were nearing the end of their cash.

Hassan and I shared a brief, hurried conversation. Hassan explained that his mother began experiencing symptoms in late 2013 and soon started undergoing examinations in Ramadi's general hospital, with occasional visits to clinics in Baghdad. When *daesh* took over large portions of the province in 2014, the hospital was destroyed and the road to the nearest treatment alternative (Baghdad) was rendered impassable. They fled to Kirkuk in order to establish a new residence and to continue with treatments. The choice of Kirkuk as a site of resettlement drew upon long-standing networks of migrants between Anbar and Kirkuk. These networks arose during the height of violence in 2005 and 2008, and they have persisted into the present. Um Hassan already had an uncle residing in Kirkuk.

A surgical procedure in Kirkuk to remove Um Hassan's breast failed, and doctors counseled them to undergo examinations at a private hospital called Al Farooq Medical Center in Sulaymaniyah province. They passed into Sulaymaniyah without any trouble. Hassan noted: "At the very beginning of the events [*daesh*], the checkpoint at Sulaymaniyah was easy. It became hard a few months later."

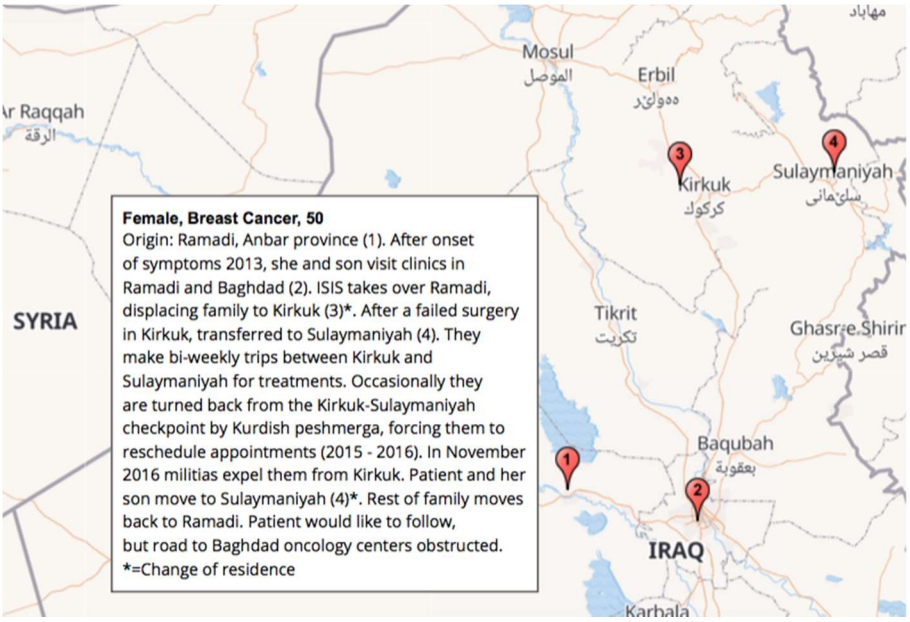

Figure 1.4: Case 2 [39]

In Sulaymaniyah, Al Farooq subsequently transferred Um Hassan to the public cancer hospital in Sulaymaniyah, where she then underwent treatments for over a year. They continued residing in Kirkuk and commuted to Sulaymaniyah for treatments (120 kilometers). Occasionally they were turned back at the checkpoint, forcing them to reschedule appointments. Hassan explained: "Sometimes at the checkpoint they say, 'what does she have?' She's not sick, she's healthy. And we always have hospital documents and everything." The ability to be recognized as sick and therefore deserving of passage into Sulaymaniyah was never taken for granted.

Since the rise of *daesh* in 2014, residents fleeing *daesh*-controlled areas have been treated with suspicion among Kurdish *peshmerga* units manning entry points into the provinces under the jurisdiction of the Kurdish Regional Government (Sulaymaniyah, Erbil, Dohuk). Patients report that checkpoint officers do not follow standardized

[39] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

procedures and routinely turn back patients. Doctors have explained that the rates of refusal are highest for patients with non-visible wounds and illnesses (e.g., cancer, psychiatric conditions); however, even emergency injuries are often stalled or refused on security grounds.

These twice-monthly Kirkuk – Sulaymaniyah trips continued for over a year until their eventual eviction in November 2016, just a couple of days before our interview. Hassan explained the decision to refuse return to Ramadi as a question of continuity of care. They could not guarantee passage between Ramadi and the only proximate location of treatment, Baghdad. Hassan explained:

> "It's better for you not to use the road between Anbar and Baghdad. It's very far, I mean a healthy person can go back and forth, but for a sick person it's very difficult…with all this suffering, in our province there is no hospital like the one in Sulaymaniyah. It's destroyed by *daesh*. And Baghdad is far."

To be precise, Baghdad had *become* far. His home province of Anbar has historically benefitted from close physical proximity to Baghdad – a mere 125 kilometers. For decades the Anbar to Baghdad nexus enabled medical referrals without much complication. Yet, Hassan now spoke of the road as "far" and "long." Notions of proximity are distorted under conditions of conflict.

Hassan abruptly excused himself from the interview. "I need to ask someone if…" He was on his way, probably having discerned that I could offer little help to alleviate his situation. In the waiting room of Hiwa's oncology unit, he approached several staff members asking if they could assist with the residency process for Sulaymaniyah. They deflected, saying they only knew about treatment-related matters. Hospital staff was

prone to enforce a separation between the clinical and security apparatus, though of course they were intimately intertwined from the perspective of displaced patients. Hassan made calls on his cell phone inquiring about apartments to rent in Sulaymaniyah. "The apartment has to be less than two papers ($200) a month, or we can't pay for it," he noted to the person on the other end of the line.

I never saw Hassan and his mother in the hospital again. They were of the many individuals whom I encountered at highly precarious points along the treatment journey. I do not know for sure if they eventually decided to move back to Ramadi or if they were able to secure residence in Sulaymaniyah somehow. When I asked the presiding oncology a few weeks later about the case, I was informed that they had not shown up for their latest appointment. Just as oncologists often experienced a sudden vanishing of their patients, I was often cut off from tracking relationships forward or into the everyday.

Case 3: Mariam

Mariam is a 57 year-old mother of 3 from Mosul, Iraq. I conducted an interview with her on a bench outside of Nanakali Cancer Hospital in Erbil. She took a sigh when I asked her to explain her "journey for treatment" (*rihlat al ilaj*). "It's a long journey," she replied. She began by explaining that as a Kurd living in an Arab-majority city, she spoke Arabic and Kurdish fluently. Her husband was Sunni Arab. This mixed background would both aid and complicate her "treatment" (*ilaj*), she noted forebodingly. Her disease began over a decade ago. It was 2005 when symptoms arose. "My mother had this disease, and many of my sisters, it's inherited," she noted mournfully. She underwent chemotherapy as well as surgery in Mosul's public hospital. As the radiotherapy machine

in Mosul was suffering from maintenance issues (it is exceedingly difficult to keep linacs up and running under conditions of war), doctors in Mosul referred her to a public hospital in Damascus, Syria for radiotherapy. Connections between doctors in Mosul and Syria have long facilitated cross-border referrals in both directions. She remained in Syria for 5 weeks. Subsequently the disease entered into a state of dormancy for 9 years.

"It returned again just 6 months before *daesh*," she noted. The first doctor in Mosul dismissed test results as inconclusive. "But then a Yazidi doctor said, go for a PET scan in Istanbul." She made arrangements to fly from Erbil to Istanbul. At a private hospital in Turkey a PET scan revealed cancer of the spinal chord. She underwent intensive radiotherapy, taking on 5500 dollars in debt. They sold a freezer and the gold from her wedding to cover the debts. She returned to Iraq, undergoing chemotherapy in Mosul.

Figure 1.5: Case 3 [40]

[40] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

Soon *daesh* took over Mosul in the summer of 2014. She could pass as an Arab and faced no major problems accessing the hospital under *daesh*. But the conditions of care were deteriorating. “I was getting treatment but the walls of the hospital were falling on us. They told me, you need to get out of here or the way will be blocked.” Moreover income sources were cut. Her husband’s small shop was overtaken by *daesh*. They decided to flee. They locked the house, thinking it would only be a couple of months before they returned.

She and her husband headed in the direction of Dohuk. At the Mosul – Dohuk checkpoint, they were stalled for a full day. The *peshmerga* told her, “You’re married to an Arab and he can’t speak Kurdish.” Eventually they were let through after the intervention of Kurdish friends in Dohuk. These friends provided a place for them to stay in a mosque for 6 months while they received treatment in the public hospital. The hospital provided doses on some occasions, and on others they had to purchase medications in the pharmacy. This was a common mode of triage. IDPs were admitted to hospitals but did not receive full continuity of care from public stocks. War has politicized medicine and created categories of deserving and undeserving; however, in the northern Iraqi context this politicization is subtler than what scholars have dubbed the “weaponization” of medicine under conflict (Fouad et al. 2018). Divisions between “resident” and “non-resident” — the deserving and only partially deserving (Marrow 2012) — do not necessarily result in a wholesale denial of care but a piecemeal degrading of its efficacy.

At the beginning of their displacement journey, people were occasionally sending funds. They were able to use these funds to move to Erbil in order to access the higher

quality public oncology centers. But public stocks were low. In Erbil they received "Zometa but not chemotherapy." Eventually they decided to attempt the public cancer hospital in Sulaymaniyah. Over the past year they have switched back and forth between Sulaymaniyah and Erbil depending on the public availability of different modalities. The last time I saw Mariam and her husband, finances occupied their main set of concerns. They were $35,000 in debt to relatives and friends, and did not have means to repay them. They wanted to go to Turkey for a PET scan, but funds were not forthcoming at the moment.

Participant Observation/Accompaniment

The forthcoming two cases combine hospital conversations with accompaniment across provincial or international borders. In both cases, I first encounter the patient in a standard clinical interview much like the ones above. The opportunity to accompany them across checkpoints and borders in pursuit of treatment emerged unbidden through their efforts to draw together a network of information and support.

Case 4: Um Hussein and Mr. Ahmed

I first met Um Hussein (53) and her husband Mr. Ahmed (57), originally from the Sunni Arab town of Hawija (southwest Kirkuk province), while conducting rounds of interviews at Kirkuk Cancer Center. Mr. Ahmed detailed his wife's care-seeking journey in the hallway of the hospital during one of her check ups:

> "In 2008, a tumor (*ghude*) appeared (*thaharat*) in my wife's left breast (*sadir al aysar*). I brought her [from Hawija] into a doctor in Kirkuk [city], the doctor, his

> name was Meesan, and he carried a surgery on her in the Hospital of Kewan to remove the tumor. After the surgery, she got into her recovery period and she actually got better. But after a while, the tumor started to appear again (*radat al ghodah marah thania*) and she had to go throw another surgery (*soweyna amilya ukhra*) in Al-Jumhuri Hospital of Mosul. After a short period, a third tumor appeared; this time it was under her armpit (*uboT*). The location of tumor had changed this time. This was before 2010. After that, the tumor got even bigger and we had to remove the whole breast (*shilna a-sadir*), this was at the beginning of 2011. The surgery took place in Al-Bawajeel Hospital, in Tikrit. Tikrit is closer to Hawija than Mosul, and so we preferred this…."

He continued with this account of tumors, roads, and a litany of treatment locations. He made no mention of etiological theories: The vast number of switches and turns in the treatment journey consumed the core of the account. I will paraphrase the remainder: Two years later Um Hussein underwent several cycles of chemotherapy at the public center in Mosul. She began in March 2014 and continued with treatments when *daesh* took over the city in June 2014. However, pharmaceuticals soon became scarce in the public hospital and they were required to purchase them on their own. Mr. Ahmed noted: "When *daesh* came, the problem with the chemotherapy was that it was of low quality and the amount of doses was little so when she gets the treatment it didn't affect all parts of her body, for instance blood cells." This questionable chemotherapy proceeded until 2015, when doctors advised yet another surgery. She underwent one surgery at the public hospital in Mosul and then another in the private hospital in Hawija. Subsequently she

underwent additional rounds of chemotherapy between December 2015 and April 2016 at the public hospital in Mosul, all transpiring under *daesh* occupation.

The Hawija - Mosul roadway was passable because of unbroken *daesh* control along the route. The likelihood of harassment was low so long as they did not make any detours from the main road. When the Coalition started making preparations for the Mosul battle in the fall of 2016, the road was cut off. Given the minimal availability of cancer treatments in Hawija and the increasingly insecurity of the area with an upcoming Coalition campaign, now they had no choice but to make an attempt to obtain entry into Kirkuk city and relocate there. They did so at great risk to their lives. If caught, "*daesh* would have probably executed us or threw us in jail," Mr. Ahmed asserted. Through paid smugglers they made the crossing in May 2016.

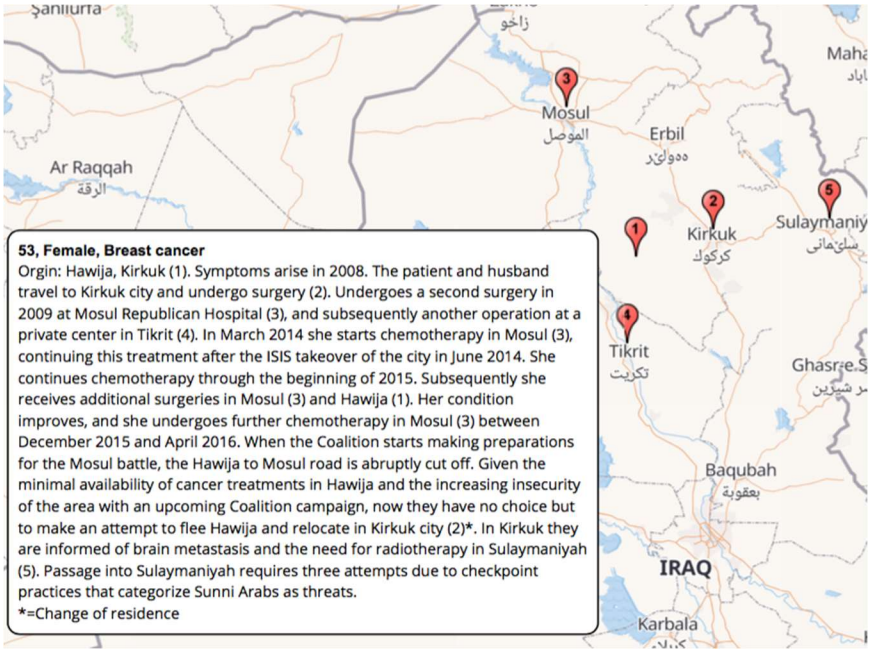

Figure 1.6: Case 4 [41]

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Now that they were safely in Kirkuk city, they had to reorient themselves to a new distribution of referrals. Doctors at the public Kirkuk Cancer Center suspected metastasis to the brain. They informed Mr. Ahmed of the need for radiotherapy. As radiotherapy was not available in Kirkuk, their referral options included Baghdad, Erbil, Sulaymaniyah (all public) or a foreign city such as Beirut, Istanbul or Amman (private). Politically Baghdad was a non-starter. He reasoned that the road southbound would expose them to abuse from the *hashd sha'abi* or the League of the Righteous (*asai'b ahl al haq*). They considered the logistics of radiotherapy in Istanbul, but soon they realized that the possibility of attempting treatment abroad was financially and logistically out of reach. They had lost all income earning capacity in the move to Kirkuk, and they were only receiving small bits of cash as gifts from sons and other relatives. Um Hussein did not possess a passport, and obtaining one would require travel to Baghdad, which again was too dangerous.

The northbound routes to Erbil and Sulaymaniyah were the only viable options, but they were also complicated by multiple factors. First, getting an appointment in the public radiotherapy centers would be difficult. A 9-month waiting line had accumulated, and IDPs would not be prioritized. Fortunately, because her case was marked 'palliative' and she only required a low level of fractions, she had a better chance of obtaining a slot within a reasonable time frame. The second problem was, once again, checkpoint access. Entry checkpoints into the KRG-controlled provinces were manned by the Kurdish *peshmerga*. Residents of Hawija were generally stereotyped as extremists.[42] Um Hussein and her husband eventually received appointments and attempted the passage into

[42] In the post 2003 era Hawija gained the reputation as a site of fierce resistance during the US Occupation.

Sulaymaniyah twice, and twice they were turned back. And this refusal came despite bearing an official referral form from the Kirkuk public hospital. For their third attempt journey to Sulaymaniyah, Mr. Ahmed requested that I make arrangements for myself and a Kurdish resident of Sulaymaniyah to accompany them across the provincial border, acting as his "sponsor" (*kafeel*). I have included a revised excerpt from my field notes below.

*

My Kurdish friend Mohammed and I drove southward from Sulaymaniyah city to Chumcumal, the town straddling the Kirkuk-Sulaymaniyah provincial border/checkpoint station (approx. 65 kilometers). Simultaneously Mr. Ahmed and Um Hussein drove north from Kirkuk city to the same juncture (approx. 50 kilometers). Mohammed and I passed through the checkpoint and met Ahmed and his wife Um Hussein on the Kirkuk provincial side, where they were waiting with a taxi driver. The idea was for the four of us to board Mohammed's car across the checkpoint into Sulaymaniyah province, and then head towards Sulaymaniyah city in time for Um Hussein's radiotherapy appointment. Um Hussein remained seated in the back seat of the taxi while Ahmed disembarked and greeted us. Transferring Um Hussein's body from the taxi to Mohammed's car (a large Toyota truck) was not an easy task. She had a catheter attached and could not walk. Ahmed embraced her from the front and pulled her out of the car. Meanwhile the taxi driver boarded Mohammed's vehicle in order to pull her up and into her new perch. Ahmed struggled to keep her body upright enough to be boarded into a seat that was significantly higher off the ground than the taxi. Mohammed and I awkwardly grabbed and spun around Um Hussein's body. Ahmed tenderly encouraged her, "Walk, walk, my

love." Her feat appeared motionless except for a slight strain forward. I now grabbed her lower body and pushed up, while the taxi driver pulled and Ahmed supported her head. Finally she was in the car. She let out an elongated cry, the first words I had heard from her that day: "eeeeeeeeh, my head, my head!" Ahmed brought her head down to his lap, taking a deep breath. I had not anticipated the physicality of transferring Um Hussein's body from the taxi to Mohammed's car.

Now with all of us in Mohammed's car, we approached checkpoint (the first of two checkpoints). Mohammed rolled down his windows in the customary manner. The officer in our lane took a quick look at our back seat (where Um Hussein was laying on Ahmed's lap) and immediately gestured for us to head towards the holding area, a small parking lot where screened vehicles await inspection. Another officer approached the car once we parked in the holding area. He greeted each of us. Mohammed replied in Kurdish. Ahmed and I replied in Arabic. He took our identification cards. Mohammed explained the situation in Kurdish.

"This man Mr. Ahmed and his wife have appointment… Mr. Mac is an American researcher…"

The officer quipped wryly (in Arabic), "What is this, an American, a Kurd, and an Arab all in one car? By God this is a first for me." He told Mohammed and I to disembark in order to speak with the presiding officer over the station. The presiding officer spoke apologetically to Mohammed and me, justifying the stoppage on the grounds of "security."

The officer inspected my two letters of affiliation (with the American University of Iraq and Hiwa Cancer Hospital, both in Sulaymaniyah) and expressed skepticism about

my employment and residency status. "So you are a doctor?" he asked. I explained that I was an American doctoral student in anthropology with research appointments at the American University of Iraq as well as Hiwa Cancer Hospital in Sulaymaniyah. "So you're a also an oncologist?" he followed. Mohammed intervened as I fumbled, saying assertively, "yes, he's an oncologist." Mohammed then explained (switching to Kurdish and thereby cutting me out of the exchange) that a Kurdish oncologist in Kirkuk had registered the patient for an appointment at Zhianawa Radiotherapy Center in Sulaymaniyah. Mohammed inserted references to his background and family name. The officer listened while looking at the documents before him. "Cancer," the officer repeated while looking at Um Hussein's referral form. "The problem is, how do you know someone has tumors?" He left the question hanging in the air. We waited another ten minutes and then the officer returned our documents. We returned to the car and passed through the checkpoint station. They never interrogated Mr. Ahmed. He and Um Hussein would remain an unknowable entity in the eyes of the officer, I thought to myself. The only question was whether or not Mohammed and I had the affiliations and connections to take responsibility for any error in judgement.

Now back on the winding Kirkuk - Sulaymaniyah road, Um Hussein was experiencing extreme discomfort. She spoke of a "block" (blok) sitting on top of her head. She held her forehead and grimaced. Mohammed slowed his pace a bit. She made quiet self-calming utterances, repeating "praise God" (al hamdulila) over and over again. Finally she burst out, directing her voice towards me: "Are you going to do anything for me ya doctor? I've got swelling in my hand, pain in my should and head, are you…?"

"I'm just in charge of your transfer to the hospital," I said.

"Then get me there already!"

Ahmed, Mohammed, and I shared a restrained laugh in response to the momentary revival of Um Hussein's assertiveness. Ahmed smiled and said to Um Hussein, "He will, my life, and the doctors will take care of you. This treatment will help you feel better."

Um Hussein was not finished with the interrogation. She maintained a piercing gaze in my direction. She described the "pain" as concentrated in her head, but also extending down into her shoulder and arms. "I also can't walk anymore, and why is this doctor?"

Ahmed leaned forward and uttered in a low but still audible register: "She knows that she has the disease in her breast, but not in her head."

Um Hussein turned away momentarily towards the window.

I quickly found myself suggesting to her that her partial paralysis has to do with the side effects of the medicine, nothing else. "Um Hussein, the walking problem, it's normal. It happens with chemotherapy." Ahmed effectively drew me into the concealments around illness.

We approach the second and final checkpoint — the one leading into Sulaymaniyah City. The checkpoint stands at the top of a mountain overlooking the city. Ahmed leaned into his seat back and breathed quietly. We drove slowly and turned down our windows in preparation for the encounter with a peshmerga soldier. The officer was consumed with his radio and barely glanced in the direction of the car before waving us

on. He did not even inspect our documents. Ahmed turned and looked back at the checkpoint, but did not say anything.

We passed through Sulaymaniyah City and made our way to the eastern zone where most of the city's hospitals are located. Upon arrival to Zhianawa Radiotherapy Center, we approached the reception desk. Ahmed passed over the letter of referral from his doctor in Kirkuk. A man took it back into the bowels of the hospital and returned a few minutes later. The receptionist informed us:

"We don't have space today, she'll have to start her treatment tomorrow, there's a lot of patients."

Ahmed said, "By God we have an appointment for today, and it's been moved twice before, because of the checkpoint, and the doctor said we'd go and come back to Kirkuk in one day."

"But sir your treatment is not for 1 day. It's for 5 days."

"5?"

"Yes, 5. 1 is impossible…"

"There are beds in the hospital for her to sleep at night?"

"No, it'll have to be a hotel," the nurse said.

With the combined force of Ahmed, Mohammed, and my pleading with the head doctor, Um Hussein was able to undergo her first few fractions of radiotherapy on that day, but 4 more days remained. As the reality of remaining nearly a week instead of one day set in, Ahmed grew agitated and expressed a number of doubts to anyone who would listen: Where would they lodge? How would they obtain the money needed for the extra stay? How would they remain for nearly a week without official approval from the

Kurdish security officials? In the waiting room Ahmed chatted with a man from an Arab man from Tikrit and Kurdish woman from Diyala who had spent the morning making similar roadway passages. Roads, checkpoints, and the discomfort of transport became the stuff of illness talk. After leaving the hospital we spent the next several hours locating a suitable hotel nearby.

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I would continue to follow Mr. Ahmed and Um Hussein's case through occasional encounters and phone calls. But for the purposes of this analysis I want to focus on the experience of the passage from Kirkuk to Sulaymaniyah. In anthropology, the study of the phenomenology of border crossings presents a methodological problem. As Jason De Leon notes in his ethnography of Mexico - US border crossings, a methodology that involves accompanying others across a highly securitized border shifts the power dynamics and vulnerabilities of the act, and might in fact place migrants in greater danger. If the migrant group is detected and apprehended, the anthropologist is far less likely to receive punishment from authorities. The ethnographic writing that results from such engagements often puts the experience of the anthropologist — his or her fears and anxieties — at the center of the narrative rather than revealing the worries and doubts of migrants themselves (De Leon 2015: 12-13).[43]

Passing through checkpoints and barriers at internal provincial borders present similar questions. My presence and that of my Kurdish friend Mohammed certainly shifted the power relations of the Kirkuk - Sulaymaniyah checkpoint crossing. However,

[43] De Leon's solution to this border is a methodology that blends interviews with ethnographic fiction: He pieces together fictionalized experiences of border crossings drawing from hundreds of interviews with migrants.

we did so at Mr. Ahmed's explicit request and in the context of an established *kafeel (*sponsor) system that operates on the basis of local KRG connections. In contrast to the notoriously brutal impromptu checkpoints manned by militias in central Iraq, the violence of the Kurdish Regional Government (KRG) checkpoints is exerted not in physical harassment or long-term detentions but through a state-like power of refusing entry to those lacking the right resources, connections, or a suitable *kafeel*. KRG health officials often contrast the semi-autonomous region as distinct from federal Iraq with a discourse of respect for basic human rights and treating all patients. In practice they have essentially outsourced triage to the security barrier encircling the KRG, a zone where 'invisible' afflictions like cancer can be discounted.

Mr. Ahmed remained attentive to Um Hussein's physical discomfort throughout the process of transport. He simultaneously wanted to ensure that she remained protected from disquieting knowledge about her brain cancer. Piecing together an expansive cancer itinerary across Iraqi provinces presents the problem of drawing a whole host of others — taxi drivers, travel companions, people in waiting rooms, checkpoint officers, etc. — into the delicate concealments around the disease. On the surface it would seem absurd for Mr. Ahmed to audibly assert Um Hussein's non-knowing of metastasis to the brain whilst referencing it in her immediate presence. Perhaps one could follow Van Hollen's (2017) line of argument and say that patients like Um Hussein engage in a "performance of ignorance" (2017: 9). Surely, Van Hollen argues, they privately harbor knowledge about the existence and specificity of their disease because treatment and hospital visits constantly thrust reminders into the patient's field of vision (signs, reports, talk, etc.). But I am inclined to think that the Van Hollen exaggerates the relationship between sight or

hearing and knowledge. Um Hussein's statue-like bodily composure at the moment of Mr. Ahmed's utterance — relaxing her face and turning slightly— suggested to me that perhaps she had cultivated capacities of non-hearing or non-seeing.

However, non-knowing both protects and exposes one to harm. How could it possibly be that Ahmed, an extremely experienced *murafiq* who had traversed most of Iraq's northern cities in pursuit of treatment and security, could not have solidified the details of the appointment and length of stay in Sulaymaniyah? Or perhaps it was a matter of the oncologist's manner of communication that led to the problem? Good et al. (1994) have suggested that oncologists tend to talk about treatment modalities through language that narrows the temporal horizon to the immediacy of the current treatment objective in part to fend off talk of the inevitable terminality of cancer. Patients learn to enter into a "narrative form" in which talk of future therapeutic steps and especially endings are never explicit (Good et al. 1994: 858). While it is possible that the immediacy of oncology practice contributed to the drawing of Mr. Ahmed's sight away from the ultimate arrival to Sulaymaniyah, I am inclined to think that the core of the issue here is something more fundamental about the experience of cancer across Iraq's emerging geography of care: Neither the movements of the illness nor of bodies across space are entirely chartable in advance of their unfolding. Knowledge is accrued and decisions are made *along the way.* I have used the word 'journey' throughout this dissertation in order to emphasize this character of unpredictable unfolding. As the next case will suggest, a similar quality of contingency characterizes passages across international borders.

Case 5: Imaan & Nabil

I first met Imaan, a 23 year-old recent mother, at Hiwa Cancer Hospital in Sulaymaniyah. Imaan entered the room where I conducted interviews with her younger sister, her *murafiq*. Imaan spoke for herself while her sister looked on. Her file read "non-hodgkin lymphoma." They were from Anbar province, and previously they were obtaining chemotherapy through twice monthly trips to Baghdad. "It was hard and dangerous going back and forth," she noted. "So we were displaced (*nzahna*) just a few weeks ago," she noted without giving further details.

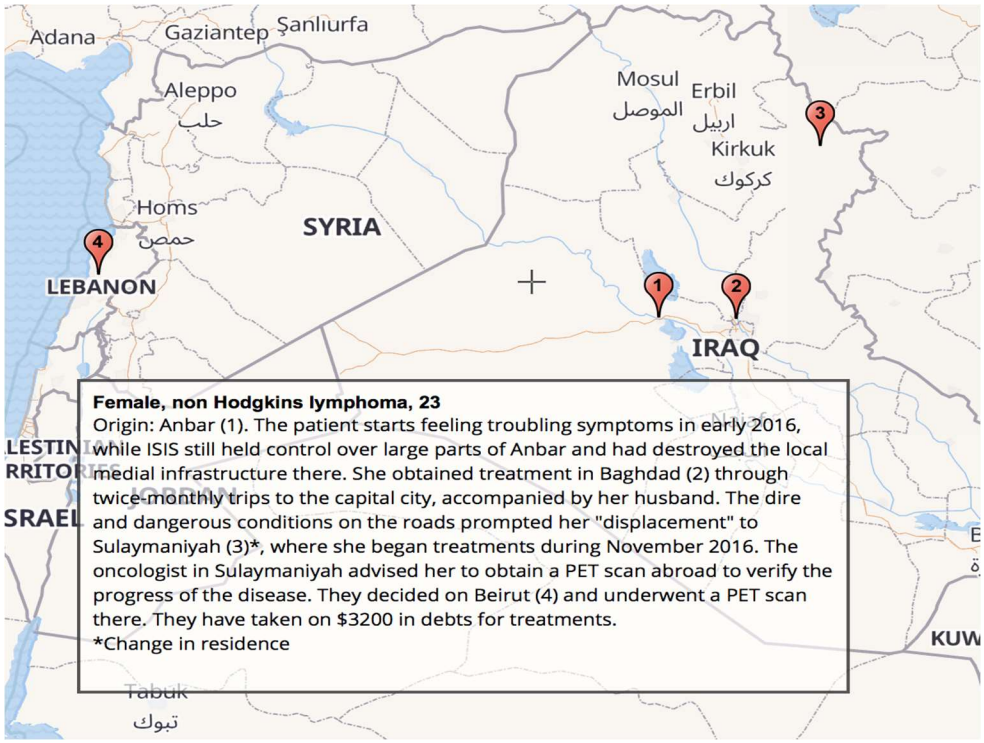

Figure 1.7: Case 5 [44]

She mentioned the "horror" (*r'ob*) of the *daesh* takeover of Anbar as perhaps related to the onset of the illness, but she quickly brushed this line of thought aside, as she was

[44] © OpenMapTiles © OpenStreetMap contributors | Scribblemaps.com

mostly concerned about the implications of recommencing chemotherapy for her hair: "We've already done 6 doses in Baghdad, and now the seventh is today at Hiwa. The doctors, they promised that if my hair starts falling out, they'll stop the treatment." She continued to repeat this assertion.

At the moment I did not have a sense of the life world in which these concerns were taking on such force. Imaan noted that one of the reasons for moving to Sulaymaniyah was the perception that the medications stocked by Kurdish hospitals were "authentic" (*haqiqi*) American brands. This very authenticity also posed the threat of side effects that possibly outweighed the benefit of treatment. In our interview Imaan mentioned the possibility of undergoing a PET scan in Beirut. I made note of it but did not anticipate following up on the matter. A couple of days later, I stumbled across the opportunity to participate in her journey to Beirut through a chance encounter at Sulaymaniyah Airport. I will include segments of revised field notes below:

*

I was sitting in the lounge of Sulaymaniyah airport awaiting my flight to Beirut for a stint of Lebanon-based fieldwork. I noticed that someone was leaning into my field of vision from a few steps away. It was Imaan from Hiwa Hospital. She was standing with a man her age in a suit, her husband I soon learned. They approached me.

"So are you going to Beirut?" I asked.

Imaan responded, "Yes, Beirut."

The husband added, "A scan, a PET scan they say."[45]

[45] While Sulaymaniyah possessed the widest range of treatment modalities in northern Iraq, it still lacked a number of features that could only be acquired abroad, namely, a PET scan. Displaced persons (*Naziheen*) residing in Sulaymaniyah were often referred to

I gestured for them to sit down at my table. Her husband engaged me in conversation while Imaan took some messages on her phone.

Me: "How long are you staying?"

Nabil: "By God they told us that we'll get the return ticket once we arrive and see the situation. But we don't know anything.

Me: "Do you have a hotel?"

Nabil: "No, we don't know Beirut. Maybe you could go with us?"

Me: Ok, I can go with you, because my hotel is next to the hospital.

Nabil: We're grateful. We don't know anything (kul shi ma n'ref). How much is the hotel?

Me: There's 50 dollars, there's 60. There's 25, but not very nice.

Nabil: I'd prefer the 25, my situation isn't great with money.

Me: What's your work.

Nabil: I'm an officer in the Army…But, well, I'm an officer working as a journalist, war news. For example if there's 10 martyrs we say just 1…

Me: We've got the same thing.

Nabil: The Americans are better at this than we are! No one even thinks about the war there, do they?

Me: You are right.

Nabil then explained the extent to which his conscription in the Army had facilitated Imaan's treatment prior to the move to Sulaymaniyah:

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treatment sites in Turkey, Lebanon, and Jordan for these procedures — in the same manner as the local Kurdish population.

Nabil: In Anbar, I can tell you, it's 5 percent out of a hundred after ISIS, I mean worn down to the furthest extent (ta'ban ab'ad hudood.) Medicine for this disease, they don't have it in Anbar at all (nihaiyan mako bil anbar). Imagine many people died because they can't get to Baghdad for treatment (Sower ba'd al murdha mato ma gidiro yowsal Baghdad.) Why couldn't they get there? Because there's a bridge, Ibzeez bridge…this is the crossing to Baghdad. From Anbar to Baghdad. And they don't want to let the Sunnis through. I'm in the army and so they let me through, but the normal person, they don't, from the beginning of the daesh events (ahdath daesh) until today. Even if he dies on the bridge. But the situation wasn't good for us either. She has to take a dose every 15 days, you go and you find 20 people, 15 people, one on top of the other (wahid foq al lakh). You finish and you go back to Anbar, but it's hard…."

We proceeded to the gate. Imaan, Nabil and I sat down on a bench next to the gate — seated in that order. Nabil leaned over towards me, not whispering but speaking softly.

Nabil: Doctor is there treatment for this disease? I mean, have you heard of someone who got this disease and then got better again?

Me: I'm not a doctor but, yes, this happens.

Nabil: Ok [pause] And doctor, this machine, what's it's benefit. What does it do?

Me: The PET scan? the PET scan will take a picture of the entire body. If there's a problem, it will come up in it.

Nabil: And this machine gives treatment at the same time?

Me: No, just diagnosis.

It was time to board our flight. We were seated in different parts of the plane. 1.5 hours later we arrived to Beirut. The Beirut airport has two lines, one for foreigners and the other for those with Lebanese passports. Nabil had not travelled internationally for many years, and he asked me for help finding the expiration date on the passport. Nabil and Imaan reached the immigration booth but were then instructed to exit the line and go back to another window where they would first purchase a visa: $40 USD each for Iraqi nationals. (Unlike nearby Jordan and Turkey, no procedures prior to airport arrival were required.)

Upon arrival to Beirut, we spent an hour going from hotel to hotel. Another Iraqi man we met at the airport from Basra said he was "bored" and accompanied us as we strolled. We selected the Weekend Hotel, one of the cheaper options. Then we needed to verify the PET scan appointment. Nabil and Imaan only had a picture of the center. "We're in this place," Imaan noted, displaying a picture of the American University of Beirut Medical Center. Nabil added: "There's a guy named Abbas who works there, I talked with him on the phone." Since neither of us had any idea where the PET Scan building was located, we shuffled around and asked nurses until we located it — the Sowwaf Building. We confirmed the appointment, and he was informed of the cost: $1000. But then we located another PET scan center that was $100 cheaper and made an appointment there. The next morning they underwent the scan and made arrangements to return to Sulaymaniyah.

*

This journey to Beirut was not unlike Mr. Ahmed and Um Hussein's journey to Sulaymaniyah in that both evoked a sense of wading in the dark, picking up details about

treatment and lodging *along the way*. Nabil, Imaan's longtime companion on regular trips between Anbar and Baghdad, did not know where they were going, where and how long they would stay, or the nature of the treatment she was about to receive, etc. This lack of a preconfigured cross-border trajectory already markedly diverges from previous studies on the processes of information gathering in transnational therapeutic travel, which have emphasized exchanges of information about treatment *prior* to embarking on the journey. Hanefeld et al. (2015) note the important role of "informal networks, including web fora, personal recommendations and support groups" in shaping decision making around the pre-selection of destinations and hospitals (2015: 356). Hanefeld et al.'s approach presumes that all major decisions around treatment options are made in the lead up to travel and do not remain in flux upon arrival. The trajectory is set in advance. It is perhaps possible that such a conceptualization might hold in contexts where a 'medical tourism' administration manages patients' treatment, accommodation and meals from arrival to departure (*See* Solomon 2011), and where 'care-seekers' are therefore empowered to take control of meticulously planning the whole scope and direction of the journey in advance. Iraqis' cross-border journeys rely upon the encounters and networks emerging amidst travel. In this case I formed a part of that network.

But these travel encounters do not always fit neatly into treatment-oriented aims. The day after Imaan and Nabil returned to Beirut, I heard from a fellow hotel guest that "my friends from Anbar" had gone through a huge marital struggle during the final night of their visit of which I was not aware. Nabil encountered a Tunisian woman at the hotel whom he requested to marry and take back to Iraq. Evidently he framed this proposal in the near-certainty that his wife would not last long. "She's between life and death" (*beyn*

al hayah wil mout) he apparently asserted, using the standard phrase to convey a serious or near-terminal state. The pair took a trip to the seaside city of Byblos together on the final day. Imaan got wind of the situation and refused to speak to Nabil for several hours. I began to think about his initial question about the efficacy of the treatment ("…have you heard of someone who got this disease and then got better again?"*),* as well as her concerns about hair loss, in a different light. Back in Sulaymaniyah's Hiwa Hospital, Imaan told me that she would continue to undergo treatment at Hiwa Cancer Hospital, and that Nabil was currently conducting business in Anbar.

Oncologists Along the Journey

The voices of oncologists in Erbil, Kirkuk, and Sulaymaniyah have not figured prominently in this chapter. This is partly a function of my research methodology: While in clinical spaces, I spent most of my time chatting with and interviewing patients and families in the hallways, waiting rooms, driveways, and courtyards as they awaited consultations. Waiting often unfolded over hours, and it was during this expanse that patients and their family members talked with me and others about their journeys of care. The consultation itself spanned no more than a minute or so. They would enter a room and exit a few minutes later. Towards the end of my fieldwork, when my position in the three Iraqi hospitals was more secure, I started to follow patients into the consultation room and took notes on the rapid encounters that unfolded. Exploring these encounters in depth goes beyond the scope of this chapter, but one point should be stressed: Patients struggled to condense the complex journeys of illness and war described above into

compact statements that could be processed and acted upon. Oncologists, in turn, had to attempt grasping these diffuse elements quickly and decisively.

One day in February 2017 I observed Dr. Lana's clinic at Nanakali cancer hospital in Erbil. The battle over Mosul 80 kilometers away was continuing to bring new patients into the hospital. In the consultation room, 15 people holding different reports encircled her desk. Local Kurdish patients as well as people from Mosul and Kirkuk placed forms before her simultaneously. Switching between Kurdish and Arabic, she spoke to each patient individually while projecting her voice loud enough to cover the whole array of assembled persons. A 50 year-old woman from Mosul approached Dr. Lana with her elderly father, a cancer patient:

"Doctor, doctor, I have one question…"

"Yes of course," said Dr. Lana, as the women pushed through to the desk.

The Mosul woman spoken softly, "My father, how long do you think he has before...I mean, we just came from Mosul, we've been under *daesh* (ISIS) for a year. I need to get my kids back to school. How long do you think he'll live? How…"

Dr. Lana listened while surveying the crowd around her. She cut then cut off the account, and directed the Mosul woman's attention to another man standing in the corner of the room. "You see this man? He's been coming here for years with different family members. This man's mother, she had very difficult brain cancer. People said no way more than a few weeks before she'll die. And she was going back and forth between here and Tikrit, right after *daesh* was expelled from there. Very stressful. Taxis. Treatment. It's not easy. But it was 2 years before she passed! By God we never know, by God we never know." Dr. Lana subsequently instructed the woman to remain in Erbil if at all

possible for optimal treatment, but if she returned to Mosul, she should visit a certain Mosul oncologist named Dr. Jabaar who evidently never fled the city.

*

Dr. Lana did not ignore the difficulty of the woman's circumstances beyond the walls of the hospital. She listened and conveyed acknowledgement. However, with the enormous load of patients and family members enveloping the space, every word directed towards one patient or caregiver seemed to increase the angst and anticipation of the others. She cut off the elaboration of the account. With the exception of the referral to Dr. Jabaar, the advice Dr. Lana gave was not specifically formulated in response to the Mosul woman's particular circumstance. Dr. Lana formulated counsel by drawing upon fragments of the stories and journeys offered up by the assembled patients and caregivers around her. As is often the case in Iraqi and KRG hospitals, she obscured any talk of precise prognostic time frames in favor of a discourse of divine providence. A detailed, practical discussion of the treatment pathway – the range of possible routes of care under ongoing conditions of war – was out of the question.

Discussion

The above cases provide a window into patients' and companions' experiences of multi-year journeys for care. The geography of cancer care has shifted under conditions of war, as patients who once sought treatment exclusively in Baghdad now route pathways of care through the cities of the Kurdish north in addition to cross-border hubs. As patients and their companions draw a range of cities in Iraq and beyond into a plane of vision, the relationship between each of the treatment hubs is not defined by prefigured

socio-spatial categories (i.e., local vs. transnational, national vs. international). A fragile sense of space and duration arise arises in Um Hussein's pained exhortation following the first checkpoint ("Can we get there already?"), and in Imaan/Nabil's disorientation in the passage to Beirut. Moreover, if we place hospitals in Sulaymaniyah, Erbil, Kirkuk, and Beirut "in their relation to each other and in relation to the eye in which they are seen" (Das 2007: 4), the key relations at stake here are simultaneously spatial, technological (relative degrees of oncology capacity), temporal (ease and speed of access), and material (financial burden). The importance and arrangement of these components vary across the cases. A robust phenomenology of therapeutic geographies must include this ground-up understanding of scale. [46]

The final two cases provide a closer look into the experience of these journeys as they unfold. Accompanying patients in their mobilities across provinces and borders reveals the contingent qualities of treatment trajectories. In both, the experience of movement is revealed to be a process of cobbling together bits of cues *along the way.* Tracking the pathway of care beyond the walls of the hospital reveals a heterogenous and variable set of actors and institutions involved in facilitating or obstructing treatment. While Spiegel et al. (2014) have discussed discontinuities of cancer care in the context of

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[46] Anthropologists have long discussed how globalization transforms space and scale: "Globalization entails a shift from two-dimensional Euclidian space with its centers and peripheries and sharp boundaries, to a multidimensional global space with unbounded, often discontinuous and interpenetrating sub-spaces. Movement in this direction has gone hand in glove with theory and research that refocused attention from communities bounded within nations and from nations themselves to spaces of which nations are components" (Kearney 1995: 549). One goal of this chapter is to describe forms of spatial reorganization beyond the borders of the nation that are not tied into processes of globalization but rather a history and present of US-led wars.

war and refugee migration, such as "being unfamiliar with the health system, delays in health seeking behavior because of competing priorities, financial limitations, or fear of persecution because of political or security issues related to their situation" (Spiegel et al. 2014: 294), researchers have yet to accompany patients along a trajectory in which such discontinuities present themselves. In experimenting with such a methodology, this chapter has shown that mobility is both a condition of displacement and a mode of accessing cancer care. We cannot cling to an imagination of the IDP or refugee as seeking cancer care within the prefigured spatial container of the "host community" or camp or even the urban environment, especially when war has dispersed the necessary technologies and actors required for healing across disparately situated sites.

Conclusion

Understanding the lived experiences of Iraq's therapeutic geographies requires a long-term, ethnographically rigorous exploration of how individuals and families navigate shifting socio-political factors across a landscape that may include multiple cities, borders, and states. Geographers have wisely called for new empirical approaches that allow us to understand health care access within the political, social, and spatial ambiguity that defines most experiences of healthcare in situations of conflict and political turmoil. The aim of this chapter has been to show the promise of anthropology in applying rigorous case study analysis to this problematic. This is particularly important in contexts of war where the dynamics of mobility never resolve into a single orienting logic or set of spatial coordinates. War has transformed borders, transformed notions of space

and distance, and disrupted both lives and the institutions that sustain them. These diffuse elements find themselves dispersed across trajectories of care.

One important but underdeveloped dynamic arising in the cases above is the fact of cost accumulation. Patients who rely predominately on the public system in Iraq nonetheless find themselves shouldered with gradually accumulating costs for outside tests and pharmaceuticals, in addition to the enormous financial burdens of war and displacement. The problem of cost is especially pronounced for patients who repeatedly move across borders and undergo sustained treatment in the private centers of cities like Beirut, a primary hub for high-tech and expensive private oncology among Iraqis. Drawing on data collected in Beirut, I examine the question of resources and treatment in the following chapter.

CHAPTER TWO

Journeys to Beirut: Financial Toxicity and Cross-border Care

Coinciding with dips in Beirut's tourism industry over the past decade, a cluster of hotels in the vicinity of the city's hospitals has increasingly relied upon a new source of business: Iraqis traveling to Lebanon for medical treatments of various kinds, particularly cancer care. Beirut has become an important cross-border treatment hub for PET scans as well as all major treatment modalities (e.g., surgery, chemotherapy, and radiotherapy). At a one-star establishment called the Weekend Hotel located a few hundred meters from Beirut's main oncology center, Iraqis seeking cancer care have consistently occupied a majority of the rooms since 2007. The televisions are often tuned to Iraqi news channels. Hotel employees assist patients with their IVs. Wheel chairs are stacked at the entrance. Patients and relatives recline on the couches near the main entrance after long days of treatments. Today, June 7, 2014, much of the conversation revolves around difficulties in securing funds for chemotherapy, tests, and MRIs. Patients pull out hospital bills and examine them line by line. A man named Abu Dhiyah notes to another in exasperation: "4 notebooks. ($40,000). The other day I was in the hospital and they said, your wife needs an MRI. $500. Go to the accountant window and pay. I said I don't have it. They said, how can't you have it? I said that I sold my house, my car, I don't have it anymore. Every week I'm going back to Basra to ask for more money."

There is a perception among guests at this humble hotel that wealthy and well-connected Iraqis "with the government" are shielded from these financial hardships through state sponsorship. Indeed, located a few city blocks away, a 4-star hotel called

the Hotel Cavalier has focused on a niche business since 2013: Medical delegations funded by the Iraqi Ministry of Health (IMOH). Patients and family-member escorts occupy nearly every room on multiple floors, where they reside free of charge, with all bills paid by the IMOH. A state-funded bone marrow transplant program for Leukemia and multiple myeloma patients draws 10 new patients per month, each allocated $140,000 for the full course of the 100-day transplant period and follow up. At meal times, they descend to the subcontracted restaurant next door, submit a voucher, and receive a dish of their choice. The Beirut hospital contracted by the IMOH communicates with the hotel reception regarding appointments. Participants in the program are not issued receipts or invoices from the hospital. “It's all on the government's account” (*ala hisab al-hakoomah*), said one participant in the program.

The disparity between the Weekend and the Cavalier, and the two groups of patients residing in them, is not as wide as it might appear. Sustaining cancer treatment and more broadly life under war, this chapter contends, generates compounding dynamics of cost accumulation over the long-term. State-funded injections of funds into a cancer journey are ephemeral and themselves produce financial commitments ultimately shouldered by kinship networks. The chapter’s analysis consists of a longitudinal comparison between self-funded and government-funded trajectories of care, arguing that a long-term approach reveals similar if not indistinguishable dynamics of both mobility and cost accumulation for patients receiving or not receiving government support. As costs accrue, so do the doubts and meanings associated with bearing them. The chapter will thus include articulations of the benefit of treatment amidst financial catastrophe. In engaging the growing conversation among oncologists and medical researchers on the

topic of "financial toxicity" (Zafar and Abernathy 2013), I contend that the current contexts of this literature — within North America and Europe — limits its usefulness for understanding a Middle East region in which the centripetal forces of US-led wars, displacements, and the destruction of healthcare systems converge in draining livelihoods and modes of support.

Literature: Financial Toxicity

"Toxicity" has long served as a framework for understanding the impact of oncology treatment in terms of side effects and impact on quality of life. Common toxicities include nausea, vomiting, hair loss, loss of appetite, fatigue, and sterility. Oncologists are expected to counsel patients about potential toxicities and to take measures to mitigate them. Underlying these symptoms is the acknowledgement that treatment harms in order to furnish the ground for healing — the paradox of oncology. Doctors must engage in "treating the treatment" while also treating the disease (Plenderleith 1990).

As part of a broader concern in the United States and Europe around the costs of health care, studies have increasingly called for practitioners to monitor and assess the "financial toxicity" of cancer treatment in addition to standard measures of toxicity, citing close relationships between financial distress, quality of life, and treatment compliance (De Souza et al. 2014). One study claims that "out-of-pocket expenses related to treatment are akin to physical toxicity, in that costs can diminish quality of life and impede delivery of the highest quality care" (Zafar and Abernathy 2013: 2). The push to evaluate financial hardship has led to the emergence of assessment models. Khera (2014)

has, for instance, created a scale between 1 and 4 (least to most financial toxicity). The "low" end of financial toxicity includes "lifestyle modification because of medical expenditure" and "use of charity grants/fundraising/copayment program mechanisms to meet costs of care." Mid-range toxicities include "temporary" or "permanent" loss of employment and the taking on of debts over and above income. The "high" end of the spectrum would include the “need to sell home to pay for medical bills,” “declaration of bankruptcy because of medical treatment," the "need to stop treatment because of financial burden," and "consideration of suicide because of financial burden of care" (Khera 2014: 3338).

Khera assumes a socio-economic context of stability — a context into which cancer enters and definitively disrupts. Patients are imagined as losing homes, jobs, and vacations because of the disease and its costly treatment. In other words, oncology is assumed to be the genesis of financial distress rather than one compounding factor amidst others. Building upon studies which have examined "catastrophic" health care payments as both resulting from and exacerbating existing conditions of poverty (Xu et al. 2003: 115), the cases of financial distress presented in this chapter will be situated within a broader context of war-related socio-economic rupture and suffering. In Iraq, high-cost cancer treatment across borders enters into an already unstable political economy of families and communities suffering a lengthy series of disruptions. Catastrophic financial expenditures associated with kidnappings and other war-related events strips kinship networks of cash, homes, and properties (Al-Mohammad 2012: 599). Any attempt to understand and assess "financial toxicity" must account for the ways in which cancer treatment strips resources that are already and continuously drained under long-term,

ongoing conditions of war. Cancer patients pay for treatments and simultaneously war and political turmoil deprives them of income, homes, and sellable possessions.

Beyond personal financial catastrophe, war generates broader shifts in the political economy of state institutions, including health care, which in turn thrust added financial burdens upon kinship networks. In the Middle East region, the proliferation of market-based medicine has exploded since the 1980s under the influence of international agencies such as the World Bank and, perhaps more importantly, the breakup of public systems in and through war. In Lebanon the surge of the private health care sector has occurred in the years following the end of the Civil War in 1992 (Inhorn 2004). Iraq has significantly privatized but has sought to maintain a public oncology system; however, conditions of war have generated mass expulsions of doctors and failures to maintain public facilities. Paying for expensive private care across borders is often articulated as the only means to return to the standard of Baghdad public hospitals with which Iraqi patients were once familiar.[47] This is not to say that the value of expensive cross-border care is a closed question. Iraqis undergoing treatment in Beirut constantly probe, doubt, and seek to justify the enormous financial sacrifices they are making in pursuit of treatment. In addition to tracking the accumulation of financial expenditures over the course of long-term treatment trajectories, the chapter will contribute to a broader conversation in oncology around how one determines the value and benefit of cancer care (Fojo and Grady 2009: 1044).

Cross-border care is ambiguously positioned in relation to household financial burdens in the scholarly literature. Medical travel is often conceptualized as low-cost.

[47] The notion of "de-development" — a forced deterioration of socio-economic life — (Roy 1999) is perhaps instructive here.

Researchers have, for instance, lauded the potential of countries such as Tunisia to serve nearby European populations seeking excellent private health care economically (Lautier 2008). Critics such as Smith (2012) have problematized this North-South trajectory of medical tourism as quintessentially neoliberal: Public healthcare systems are neglected in favor of massive government resources directed towards privatizing health care systems, which in turn become marketed as attractive "affordable" options for foreigners, I.e. Westerners. Meanwhile locals can neither pay for private care nor enjoy the benefits of increasingly elusive public care (Smith 2012). The underlying assumption of both advocates and critics is that the customers of such medical services originate from a resource rich context (e.g. Europe) while the care provider is situated in a resource poor country (e.g., Middle East, South Asia). Kangas (2010) has forwarded an important counter of this model, arguing that inequalities within the Middle East leave patients from resource-poor countries such as Yemen no choice but to seek health care in medium income countries such as Jordan.[48]

Before proceeding to the cases I should make a few additional reflections on this literature as it pertains to the context we are discussing. Though I do not engage thoroughly the data I collected from interviews with doctors and nurses, broadly speaking oncologists I interviewed in Beirut routinely suggested that most Iraqi patients were upper class and therefore wealthy: "A poor person can't get in a plane and travel to Beirut, they are with people with money," one young oncologist said in an interview. Mobility

[48] Likewise Crush and Chikanda (2015) describe what they call “South – South” medical tourism, distinct from the more paradigmatic “North – South” trajectories. In south – south medical tourism, the poor and medically marginalized populations of the Global south are forced to rely on treatments in better resourced countries in the Global south (Crush and Chikand 2015: 314). See also Roberts and Scheper-Hughes (2011).

across borders, in this understanding, indexes the possession of wealth. Fortunately, there has been an effort at the American University of Beirut Medical Center led by Dr. Deborah Mukherji to address this set of assumptions among Beirut-based oncologists, and I have been included in this effort. When a group of oncologists and myself conducted a preliminary study of 60 Iraqi patients at the American University of Beirut (Mukherji et al. 2018), we found that fifty-four respondents (90%) reported high levels of financial distress. Patients relied upon the sale of possessions (48%), homes (30%) and vast networks to raise funds for treatment. My own interviews with Iraqi patients in Beirut between 2012 and 2017 have indicated that, perhaps paradoxically, it is often vulnerable and lower-status individuals lacking the connections to acquire scarce public resources in Iraq's health care system that are forced to travel abroad. In the first case presented in this chapter we will explore an example of such a person.

It is important to note that Iraqi patients and their companions are aware of the gap between oncologists' perception and reality. A breast cancer patient in the study quipped: "The Lebanese doctors see an Iraqi, and they say ahhhhh yes, he's carrying a barrel of oil with him." The reference to oil is particularly poignant in that Iraq's vast oil resources generate ambiguity around the economic status of the country and its citizens. This ambiguity arises both in Beirut-based doctors' discourses about Iraqis, and in Iraqis' discourses about themselves. In the lobby of the Weekend hotel, patients from across Iraq's 18 provinces often asserted that, if not for the corruption of the Iraqi and/or Iraqi Kurdish governments, each citizen should receive an annual salary on par with that of the Saudis and Emiratis. They described "Iraq" not merely as wealthy but as enormously so, and they depicted "Iraqis" as financially "weary" *(ta'baaneen*) solely due to the "thieves"

(*bowageen)* in power. The presence of the state-funded bone marrow transplant program in Beirut – and the $140,000 price-tag per patient – provided a powerful local manifestation of the enormity of the wealth of the Iraqi state and simultaneously the disparity between the well-connected and ordinary people. Again, one argument of this chapter is that this disparity, while significant at a specific point in time, appears differently when one takes the government-sponsored cases forward over a multi-year period, and backward across the various sites of treatment prior to admission into the government program. Cancer journeys spare no one from financial catastrophe.

Method

I should note prior to commencing that the cases presented in this chapter take on a different shape than those discussed in chapter 1 as an outgrowth of the methodology employed. While chapter 1 largely drew upon a mix of hospital interviews and brief periods of accompaniment across borders, this chapter draws upon periods of residence and hanging out in the two Beirut hotels already described. Unlike the anonymous modern hotel lobby depicted by Kracauer (1999), where people go "to meet no one," the encounters in the lobby of the Weekend Hotel resemble more closely portrayals of the sociality of medieval Mediterranean hostels or *funduq*, which were characterized by comradery and encounter among the pilgrims, wayfarers, and travelers converging upon them (Constable 2004; Siddiqui 2015). The Weekend Hotel's lobby burst with conversation, jokes, and accounts shared among patients and guests. Iraqis from the country's 18 provinces were brought into a common social setting.

It was possible for any guest, or a researcher such as myself, to insert herself into a certain daily rhythm of sociality in the lobby and patio spaces. Participating in the lives of patients and family members during their treatment trips to Beirut afforded me the opportunity to witness the unfolding of the illness within the everyday, albeit a dislocated and fleeting everyday. During the summers of 2012, 2014, and 2015 as well as a total of five months spread out between August 2016 and June 2017, I resided in the Weekend Hotel with smaller stints at the Hotel Cavalier. As patients often returned to the hotel over the course of a lengthy illness trajectory, I was able to reengage their stories at different points. Each of the three cases presented here draws upon dozens of conversations and encounters spread over multiple years. Before engaging the 'government-funded' cases, let us engage a case of self-funded treatment.

Case 1: Um Amir

I first met Um Amir after a radiotherapy appointment. I was sitting and chatting with others in the lobby of the Weekend Hotel when Um Amir entered and took a seat in the middle of the couches. She did not waste time in joining the chorus of complaints over the prices of the hospital. She challenged one man, saying: “You’re complaining about 40 papers ($4000)? I’ve spent two notebooks ($20,000) and it’s not enough.” The man seemed irked by the comment but quickly adjusted his grimace to a smile when Um Amir offered to cook him soup that evening. “It’s nothing to make you soup. Everyone here has had my food… and I’ve found where you can get vegetables for cheap.” She elaborated, holding a bag of grapes: “This one I got for 1500 lyra per kilo at Sabra market, and in Spinney’s it’s 3000! So 1500 lyra is the difference. And these [holding up

French baguettes], I got five for 1000!" Um Amir always advised us never to go to Spinney's for produce.

Um Amir is a 56 year-old woman from Baghdad, Iraq. She has breast cancer. When she learned of the disease in one of Baghdad's public hospitals, she was informed of the need for an immediate surgery, and after two months they would conduct chemotherapy. She heard from other patients in the hallway of the hospital that this protocol (surgery then chemotherapy) was sub-optimal and would result in a return of the disease. She was urged to go to Beirut where they would administer chemotherapy prior to the surgery, and where medicine was "precise" (*daqeeq*). (We will address the notion of *daqeeq* more closely later.) Raising the funds required selling her family's home, a sale that alienated Um Amir from her surviving brothers and male relatives. Her lone son and favored brothers died in the war, stripping her of income and supports. She never spoke of a husband, and I did not ask. "My sisters have helped me," she noted in a conversation, "but my brothers are hard men." Traveling alone without a companion (*murafiq*), she underwent six months of chemotherapy and subsequently radiotherapy in Beirut.

Expenditures mounted rapidly. Every 21 days she travelled to Beirut for a sitting of chemotherapy, spending $2000 each time. She wanted to return to treatment in Iraq following chemotherapy in order to avoid further costs, but Baghdad public radiotherapy centers did not provide her a spot within a timeframe she deemed reasonable: "Eight doses I completed, going to Beirut for a few days each time. Then the surgery. And after the surgery they said radiation. I tried Baghdad and they said in 6 months! In six months

I’d die! I don't have *wastat* (connections) in the [Baghdad] hospital, I don't know anyone.”

Thus Um Amir came to Beirut again, this time for 60 days of radiotherapy. The $18,000 treatment required additional sales of assets — assets she only partially owned. The sale of a family property angered her brothers to the point that they have ceased contact with her. Yet, Um Amir insisted that she was not entirely devoid of male companionship. She carried with her a large envelope of pictures of the person that would have been her *murafiq*, her deceased son Amir, who died in the sectarian war (*taifiya*) of 2006. She showed any hotel guest who was willing pictures of his grave in Najaf — the cemetery famous among Shia Muslims worldwide. "He is always with me," she noted to a group assembled in the lobby, "and he visits me in my dreams."

Um Amir often joined with the men assembled in the lobby of the Weekend Hotel, the bulk of which involved discussions of hospital payments and finances. It was unusual for women to take a seat in the middle of the lobby with the men. Normally they took up perches alongside the edges and joined the conversation intermittently. But Um Amir's age and lack of a *murafiq* made her full embrace of the hotel's predominately male sociality acceptable from the viewpoint of the men. "She's in a bad situation, she's lost everyone," they would say of her. Um Amir engaged in conversation among the men on her own terms. In discussing her own finances, she merged talk of expenses with talk of the loss of her son and the powerful emotions this had caused.

> "A notebook ($10,000) here. A notebook there. They're always sending me to the accountant window. And the cucumbers, vegetables here in Beirut are expensive. So is the hotel. But I can't get treatment in Baghdad. I have no choice but to come

here. There it's crowded. The medicine isn't precise (*daqeeq*). People are stressed, even the doctor. There's not enough beds. And the doctor says, What's your problem? Or, there is no room. How can he say this? The state of your soul is half the treatment. This disease, I mean, it's from *qahr* [Speaking softly]. My son, he's gone. And many sons are gone. Here I'm at the hospital and the nurse asks, how are you? And this makes me relax (*artah*)." [She weeps and wipes her eyes]

I have avoided a direct translation of *qahr* because the word is nearly impossible to translate. As *qahr* repeatedly emerged in Um Amir's conversations over her diminishing cash and property reserves, we should endeavor to understand the word more precisely. In the Quran the root *q-h-r* is used sparingly, usually in the active participle form (*al-qahir*) in reference to God as the vanquisher, conqueror, or irresistible one. *And He is the subjugator (al-qahir*) *over His servants. And He is the wise, the acquainted (Sahih International 6:18:2)*. Here *al qahir* is the one who presides over and subdues his creation. The only time *q-h-r* appears as connoting damage or harm comes in verse 93:9, this time in the form of the second person singular imperfect verb. *So as for the orphan, do not oppress (taqhar) him.* Here the imperfect verb form of *q-h-r* is associated with the oppression of the vulnerable, distinct from the victorious conqueror of the active participle form. Building on the Quranic usage, *Qahr* may also convey the subjugation and vanquishing of a person in and through grief. One of my bilingual Iraqi informants noted (in English): "*Qahr* can mean something like grief, but *qahr* is also a feeling of injustice, like something happened that shouldn't have happened. It's forced on you." Compulsion and sorrow are brought together.

Qahr is simultaneously enfolded into explanatory models of the illness and relations of care or neglect. In Um Amir's reflections above, a critique of overcrowded medical institutions and overly brusque doctors in Iraq emerges out of a sense that doctors should orient their mode of engagement with the patient according to the pervasive reality of *qahr* afflicting the populace.[49] The stakes of the doctor's handling or mishandling of *qahr* were high: It could generate or worsen cancer. The management of powerful emotions was closely tied into the necessity of Beirut as a site of care, justifying the high financial cost.[50] This was a key aspect of the benefit of cancer care for Um Amir.

The massive costs of treatments were, however, negatively tied into the workings of loss and *qahr*. In an interview I conducted with Um Amir, she drew together the financial consequences of treatment and the loss of her son:

> UA: The main thing is the cost. It's a big problem. Whoever comes here has to sell everything, his stuff, his house. PET scan, examination, flights. With all that plus the airplane and hotel it's 89 papers ($8900), I mean during the chemotherapy

[49] Scholars have shown how moral or physical injuries are often associated with the onset of cancer, creating a disconnect with doctors who see the disease onset and management in technical or biomedical terms (Hunt 1998). In contrast, Um Amir is not suggesting that the disconnect between the care she receives and the care she desires in Iraq is the result of divergent etiological frameworks between Iraqi patients and Iraqi doctors, but rather that the broadly deteriorated moral/institutional grounding of medicine in Iraq renders doctors inadequately positioned to care for people whose states of the soul (*Hala nafsiya*) are afflicted by *qahr* and other destructive emotions.

[50] This experience was not confined to women. Talk of male affliction by *qahr* was not uncommon. *Qahr* is often used to legitimize male expressions of vulnerability, weeping, and sadness. This is dubbed the "*qahr* of a man" (*Qahr al-rijal)*. One commentator on *qahr al rijal* states: *"Qahr al rijal* is a negative feeling that a man might feel in his soul, causing him severe discomfort and indignation because of the inability to change that which caused him this feeling...And this feeling is only felt among true men whose characteristics are found in the Quran. Not every male is a man who can be described as having true masculinity (*rajoola haqiqiyah*)." [translation mine] (See Mush'al, T (2016) *Ma ma'na qahr al rijal.* [What does qahr of the man mean?] https://mawdoo3.com/الرجـال_قهـر_معـنى_ما)

alone.

Mac: How'd you put that money together?

UA: From stuff we sold. My sisters helped me. We sold a property. But my portion (*husti*) was not all of it. It [the property] was shared with other people. My portion was 17 million dinars. And the house went away (*rahit*), and my son went away (*rah*). [She cries, weeping her eyes with the edge of her abaya as she often did.]

Mac: [Trying to change subject] So is your doctor good? Are you comfortable with him?

UA: Yes, he is, but the sum is very large. Every 20 days I was coming [for chemotherapy]. 2 million dinars. Each dose. And then they want a test. An MRI. A PET scan. Each one I have to go to the window. It's a lot. I wish there was a hospital like this in Baghdad, I wish, even an American one. Or maybe they bring doctors from Lebanon to Baghdad. Why are we here paying and getting tired and we have to come, sleep here? All the money. I would have more money to visit my son and fix up his grave. See the lights I put on it! [pulling her phone out of her purse and showing a picture]. I would do more…

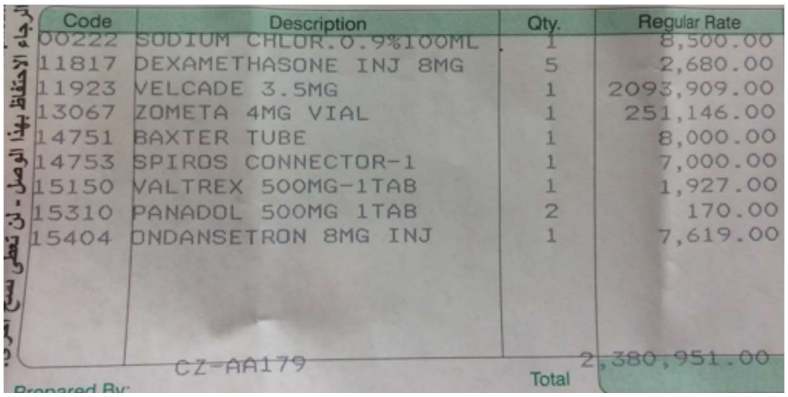
While a major part of the value of high-cost cancer treatment came in the form of doctors' capacity to tread carefully with the powerful emotions resulting from her son's death, here we see in Um Amir's expressions that the costs of treatment were simultaneously stripping her of the resources needed to maintain a relationship with her deceased son through regular visits to his grave. Um Amir was caught in a bind whereby

amassing the resources necessary to remain alive required a partial neglect of and removal from the primary animating source of that life, the site of her son Amir's grave.

*

In Um Amir's case, as a reflection of the broader set of self-funded patients, costs and debts accrue according to a piecemeal pricing mechanism whereby both large expenditures and small services/tests compound. At the American University of Beirut and most other Beirut oncology centers, treatment payments are made on the day and hour of the immediate service at hand. Patients and their companions take cash to the accountant window and then receive a receipt, which they then deliver to a clinical nurse who approves the execution of the said service.

In the lobby of the Weekend hotel, patients and companions often compared bills, expressing alarm and moral outrage at the sums that were quickly accruing. During a conversation in the lobby in which Um Amir shared, another patient (a participant in this study) placed his bill on the table and requested help with conversions between Lebanese Lyra and US dollars. In the figure below one can see that the main charge was for 3.5 G of Velcade – a chemotherapy agent typically used for multiple myeloma and mantle cell lymphoma. The charge of 2,093,909 Lebanese Lyra (LL) amounts to approximately $1381 USD, and the total sum of 2,380,951 LL is roughly equivalent to $1523 USD. He wanted to verify each of these expenditures and corresponding exchange rates. He read out each line while another person made the tally, and then the conversion to US and finally Iraqi currency.



Code	Description	Qty.	Regular Rate
00222	SODIUM CHLOR.0.9%100ML	1	8,500.00
11817	DEXAMETHASONE INJ 8MG	5	2,680.00
11923	VELCADE 3.5MG	1	2093,909.00
13067	ZOMETA 4MG VIAL	1	251,146.00
14751	BAXTER TUBE	1	8,000.00
14753	SPIROS CONNECTOR-1	1	7,000.00
15150	VALTREX 500MG-1TAB	1	1,927.00
15310	PANADOL 500MG 1TAB	2	170.00
15404	ONDANSETRON 8MG INJ	1	7,619.00

CZ-AA179

Total 2,380,951.00

Figure 2.1: Hospital Bill

One exception to this payment model is the emergency room, where bills are delivered after the fact. Because Lebanon's essentially open border (as compared to Jordan and Turkey's visa regimes) allows for a rapid cross-border trip from any major city of Iraq, many of the cancer patients who arrive to Beirut are already in a critical or near-critical condition. For example, after one of Um Amir's rounds of chemotherapy, she travelled back to Baghdad and immediately felt very sick. She thought it was something serious, and she returned to Beirut within 5 hours. It turned out to be nothing more than acute nausea. But in many cases the situation does prove serious, and patients come back to Beirut for urgent care and meet their demise days or hours later. Death in Beirut is expensive. Not only is end-of-life care in the emergency room exorbitant, the costs of the mortuary facility and airline transport of the corpse likewise add significant expenses. The frequency of this situation has presented an ethical and logistical quandary for the oncology center at the American University of Beirut. When patients arrive to Beirut in a critical condition they are typically encouraged to return to Iraq if at all possible. One oncologist complained: "Maybe it’s something with the dialect, but most don't seem to get it. They stay here till the end."

The hospital bill (pictured above) was regarded by the guests as the crux of the moral and material problem with cross-border treatment. The "exploitative prices" (*as'ar istighlail*) were on the lips of nearly every patient residing in the Weekend Hotel. I do not have the strength and emotional energy to write extensively about all the families who sold houses, cars, and took on debts only to see their loved one die while in Beirut. But it was not an uncommon occurrence. The very first patient whose case I followed closely died in Beirut after two months of back and forth travel. I watched as his son argued with doctors about emergency room costs in addition to the mortuary facility about the transport expenses. Lacking any extra money whatsoever, he had to threaten the hospital that he would leave the corpse in the morgue and return to Iraq if they did not waive or reduce the emergency room fees. Fortunately, they were able to come to a compromise, and his father's body was released.

In the context of witnessing these struggles, fellow hotel guests tended to justify remaining in Beirut either in the language of doctors' emotional care and attention as discussed previously, or in the language of "precision" (*Diqah*). The word does not require as extensive of an elaboration as *qahr*, but its importance merits a brief discussion of its usage. Um Amir once remarked:

> "I sold my house, and my car. But the people said Beirut is better, especially for breast cancer. They'll do chemotherapy first. They'll attack it. And then they'll do the surgery. More often, people said, in Baghdad they do the surgery and then the disease comes back. It's all *kilowaat (*bullshit, lies) in Iraq. But they're *daqeeq* in Beirut."

This notion of precision (Lebanon) and the lack thereof (Iraq) was intimately tied to a historical consciousness around the decline of Iraqi medical institutions. Patients

complained that doctors in Iraq lacked the training and the machines to diagnose effectively. Appeals for the importance of "international trainings and courses" rung through the hotel lobby. This particular imagination of medical professionalization is firmly rooted in an awareness of the transnational processes Dewachi (2017) describes in his book on the history of the Iraqi health care system: Between the 1920s and late 1980s, the Iraqi medical doctor was constituted through a close educational relationship between London and Baghdad. Iraqi patients expressed hopes of a return to this system in order to reestablish “precision” back home.

The attribution of "precision" was not an uncontested one, however, even for those undergoing treatment at the highly touted American University of Beirut. For many patients and their companions, the notion of precision was closely associated with the branding of the hospital as "American." One doubtful “companion” (*murafiq*) noted after handing over a sum of cash to the accountant window: "We were expecting something incredible with the American university. Something precise (*daqeeq*). I mean, just imagine the technology. George Bush sent a missile through the window of a hotel room just to kill a target. From space. And so we were expecting American medicine to be something, something *daqeeq*. But really it's all Lebanese doctors here anyway. They said the administration is American. We'll see." Wars had proven the destructive powers of American precision technology, and now the man expected to see these powers turned towards healing. He was increasingly unsure whether the cash he was handing over would yield such awesome results.

Guests at the Weekend Hotel were well aware that a select set of patients – the participants in the government-sponsored delegations – never had to deal with bills like

the one pictured above, at least while in Beirut. There was considerable talk of this group and a sense that they lived in a totally different plane of experience in relation to the disease and its treatment. The forthcoming section will suggest that, when viewed over a long-term trajectory, the two groups were not as different as they appear. I am presenting these cases in more meticulous detail in order to follow patients across a lengthy period and to show that, in fact, the imagination of a patient who receives treatment "on the government's account" (*ala hisab al hakooma*) as somehow immune from financial catastrophe is highly flawed, particularly in a context of war and political turmoil.

Case 2: Salim and Kawa

I first encountered Salim and Kawa, two brothers from Tuz Khormato, in June 2014 at the Al Baghdadi Restaurant in Beirut. They were sitting among many other Iraqi patrons. Salim breathed through a mask and consumed his meal deliberately. Kawa, evidently his *murafiq*, bounded from table to table exchanging greetings with other Iraqis. Though ethnic Kurds, they spoke fluent Arabic because of Tuz Khormato's mixed composition. Since 2003 control over the Kurdish-Arab-Turkman city has been split between Kurdish *peshmerga* units, the Iraqi Federal Army, and the *hashd sha'abi* (PMF) militias. "It's a tired situation" (*wadha ta'baan*), Kawa explained to a man from the southern provinces of Iraq, where conditions are currently more stable. This instability contributed to severe economic realities. Salaries in Tuz had been cut several times.

When it came time to pay for the dolma, chicken and rice descending upon the tables, all the assembled Iraqi guests handed over money — except for Kawa and Salim. When Kawa instead passed the waiter a white slip, I asked him what this exchange

meant. He explained that the slip was a voucher from the American University of Beirut Medical Center and the Hotel Cavalier, which were both subcontractors for the Iraqi Ministry of Health. His brother Salim was receiving a bone marrow transplant on "the government's account" (*ala hisab al hakoomah*). He elaborated: "They don't have bone marrow transplants in Iraq. So they send patients to Beirut, India, and Turkey. It's like over 10 notebooks ($100,000) per patient! Imagine if they spent this money on hospitals in in Iraq! Thieves!" This critique of the government gained the approval of other patients and companions assembled, none of whom were beneficiaries of the government program. "They're all thieves (*bowageen)*," people repeated over chicken and rice. I wondered if Kawa was, by making such assertions against the government, ensuring that he was not also lumped into the category of the *bowageen* by virtue of his participation in a program that devoted such massive resources to select patients.

This was my first encounter with members of the government treatment abroad program, although I had heard of its supposed existence previously. The program represented an unattainable goal for the self-funded patients whom I had interviewed at the Weekend Hotel: "Applying is like beating your head against the wall, unless you have connections," I was once told. Salim and Kawa did not contest this narrative, and yet they wanted to ensure I understood that the story was more complex than might meet the eye: "Mr. Mac, everything requires connections (*wastat*) in Iraq, but it's still not easy for us." I wanted to understand the journey that had led them to Beirut via the government program, and the nature of struggle to which he was hinting. I started spending the evenings at the Hotel Cavalier where the government delegations were housed. Kawa and Salim recounted their story.

From Salahadin to Erbil and India

Over the course of several conversations (and eventually several years) Kawa and Salim recounted a lengthy treatment itinerary, which began in 2012. The disease diagnosis surfaced through the treatment process for an unrelated injury. Salim's foot was crushed in a car crash in their hometown of Tuz. Salim was serving in the Army and could have easily arranged treatment in Baghdad through military connections. But neighbors convinced him of the superior quality of care in the hospitals of the Kurdish Regional Government (KRG), both private and public. Salim's brothers made arrangements for surgery in the autonomous region's capital city, Erbil, roughly three hours from Tuz. As ethnic Kurds with a branch of the family residing in Erbil, entrance into the KRG would not pose an obstacle. They gathered $2500 and he underwent the operation in a private hospital. Salim showed few signs of progress following the surgery, however. Kawa subsequently made arrangements for Salim to travel to Pune, India, where he had previously obtained a computer science degree. "It was there that [doctors] discovered cancer, in India!" Kawa related. Instead of undergoing the foot surgery, Salim began chemotherapy for multiple myeloma in Pune. Treatment costs in India reached $10,000 USD over four sittings of chemotherapy. They quickly reached the limits of their funds.

Concealments around the cancer diagnosis limited the capacity for raising resources and requesting international cash transfers. The two brothers wanted to avoid revealing the disease to their parents at all costs. Kawa explained: "My mother and father, they are always worrying about what will happen to us, after every explosion, I'm afraid

she'll have a stroke. There are people who have died from hearing the word cancer," he said. In the years following the 2003 US-led invasion, Tuz had been transformed into a theatre of war. Young men like Salim and Kawa avoided errands after dark for fear of accusations of violating curfews. The brothers did not want the news of Salim's cancer to add to these worries, which they feared could threaten their parent's health. They carefully maintained the fiction of undergoing operations in India for Salim's foot. As they struggled for the sake of Salim's life and well-being, they also labored to preserve and attend to a broader web of relations.[51]

Faced with possible financial catastrophe in India, the only option was to save money by returning to the public system in Iraq. At Kawa's urging, Indian doctors communicated with the Hiwa Hospital in Sulaymaniyah, widely recognized as the most advanced oncology hospital in the KRG. Hiwa confirmed the availability of the appropriate medications. They made arrangements to return to Iraq.

Erbil and Sulaymaniyah

As a public KRG institution, all chemotherapy treatments at Hiwa Cancer Hospital would be nearly free of charge. Kawa described the payments as "something symbolic" (*fad shi ramsi*): 500 dinars for entrance, and 500 extra for each additional test (approx. 40 cents USD). At Hiwa, Salim received a dose of chemotherapy, but hospital supplies of the necessary drugs were purportedly running low. He was informed of the need to purchase the medication themselves or consider treatment elsewhere. They

[51] Here I am thinking of Al Mohammad and Peluso's (2012: 49) discussion of the forms of kindness, care, and attentiveness by which Iraqis have been able to preserve one another and live through the post-invasion era.

started checking the prices of chemotherapy agents at local pharmacies. They soon found that obtaining the same drugs they had received publicly at Hiwa Hospital would have cost thousands of dollars each month if purchased at the pharmacy. Kawa and his brothers searched for other public options.

This was the first time I had encountered an ethnic Kurd who reported such a "shortage" at a KRG hospital. I asked a Kurdish oncologist in Kirkuk who once reviewed Salim's case for his perspective on this part of the story. (As Kirkuk oncologists often refer patients to KRG hospitals, I assumed that he would have insight on questions of triage.) He said:

> "Well this is in fact not surprising. It's easier for the Kurds of federal provinces [to access KRG public hospitals] than the Arabs, but still difficult. KRG hospitals want to show like they support the all Kurds from federal provinces. So they will definitely admit a Kurd from Kirkuk or Salahadin, and definitely give a dose or two. But then often that's it, they try to refer them elsewhere, sometime to another KRG hospital, and sometimes back to federal ones. As long as they can count them as an admitted patient."[52]

Salim was caught between two public healthcare systems, Kurdish and federal. This dynamic would continue over the course of the treatment journey.

Salim and Kawa managed to obtain a transfer of the file to Erbil's Nanakali Cancer Hospital, another KRG public institution. Salim underwent approximately 20 sessions of chemotherapy at Nanakali during 2013 at no charge. Kawa took turns with his brothers in accompanying Salim on the daylong journeys. They would typically drive

[52] Interview between the author and a senior oncologist at Kirkuk Cancer Center, December 1, 2016.

three hours from Tuz to Erbil in the morning, undergo several hours of chemotherapy, visit their extensive Erbil relatives, and then return home to Tuz all in a single day. When treatment demanded multiple consecutive days in Erbil, they lodged with relatives and thereby avoided additional travel costs. Salim sought to avoid overnight stays if at all possible, however, in spite of the negligible financial burden.

The presence of relatives in Erbil was a product of earlier wars and displacements. During the *Anfal* campaign of the 1980s Saddam Hussein's military killed and expelled hundreds of Kurds from areas of Kirkuk and Salahadin, and many fled to Erbil. This fate befell portions of Salim and Kawa's kinship network. Consequently, Salim's relatives were now concentrated within a central node in the geography of cancer care, providing him with access to support and resources in close proximity to Erbil hospitals. But Salim spoke frankly about the fact that this legacy of war had drained his relatives of their capacity to offer assistance and hospitality: The forced evictions and killings of the 1980s caused many people in Salim's relatives "stress" (*dhaght*) and financial ruin. Some came down with strokes (*jalta*), and others suffered from malignant tumors. Many had struggled to reestablish themselves in terms of livelihoods. Salim wondered whether his own disease might be related to this wider network of affliction. With this background, we can understand why Salim and Kawa preferred brief visits to relatives in Erbil.

These regular journeys between Tuz and Erbil brought Salim and Kawa into contact with new networks and connections. We should now recall Kawa's mention of "connections" (*wastat*) enabling entrance into the government program for bone marrow transplants. Kawa explained:

> "We were going to the doctor in Erbil…The taxi driver told us that his sister and nephew went to India through a program sponsored by the [federal] Iraqi Ministry of Health. A taxi driver! I said how? What? The taxi said there's a person in our city Tuz that knows the deputy Minister of Health…If you communicate with him, he'll speed things up with the Committee."

After contacting the said individual, soon they started receiving communications from the Baghdad-based Iraqi Ministry of Health (IMOH) requesting Salim's case history and recent reports. Knowledge of the government program and the crucial contact arose out of a happenstance conversation, a fact that highlights the difficulty of gaining access to knowledge under conditions of war and the unraveling of state institutions.

Beirut

After 17 days, the IMOH notified Kawa and Salim that their case had been designated for the American University of Beirut Medical Center (AUBMC). They received two plane tickets at no cost, one for Salim and one for Kawa. Upon arrival to Lebanon, the hotel concierge informed them that an administrator from the hospital would contact them shortly to explain the procedure for the bone marrow transplant and recovery period, which would last 100 days. The hotel, as a subcontractor of the Iraqi Ministry of Health by way of AUBMC, became a satellite extension of the hospital administration. The hallways were filled with members of the treatment delegations. Salim soon underwent an allogeneic hematopoietic stem cell transplant at AUBMC and remained in the hospital for several weeks. Even as his health recovered over the next three months, Salim rarely left the hotel room other than for meal times. He sought to

avoid expenditures in the high-end tourist-district in which the private hospitals were located. Moreover, walking remained a struggle due to the lingering condition in his foot.

One upside of continuing problems with Salim's foot was that it provided a plausible cover: Over the course of two years of treatments, the brothers had still managed to keep Salim's cancer a secret from their parents by saying that they were undergoing surgeries related to his foot. But one challenge in maintaining this elaborate, transnational concealment was the question of raising resources. They could not rely on their father's savings, possessions, or networks. Thus far, they had avoided the need for mass expenditures through navigating public care in the KRG and federally-sponsored care in Beirut. Unlike many of the other delegation members, they avoided making any additional expenditures in the city famous for its tourism and entertainment.

This avoidance of expenditure came to a breaking point towards the end of Salim's 100-day government-funded treatment period. As his condition improved and he regained mobility, the problem of his still-injured foot resurged into his field of awareness. Salim wanted to investigate the possibility of undergoing a surgery at AUBMC through the government program's budget. His logic was twofold: First, the persistence of his injury would mean that, regardless of the status of his cancer, he would not be able to return to the Army. Second, two patients in the delegation had died in the early stages of the transplant. Surely the overall budget for the delegation — $140,000 per patient— would have excess funds accordingly. The request was immediately denied by the hospital administrator in charge of the program. And they could not possibly pay the estimated $25,000 amount required for the surgery on their own funds.[53]

[53] An interview with Ghassan Abu Sitta, AUBMC physician, shed light on this refusal from the standpoint of the hospital: "The government of Iraq assigns a certain amount for each patient, and

Salim's final days in Beirut were filled with bitterness towards the hospital as a consequence of this denial of support. He had never trusted the government functionaries in charge of the program from the Iraqi side: "If they were doing their job properly instead of stealing, we would have this treatment in Iraq," he would often remark in disgust. But he had generally excluded AUBMC from this moral condemnation, emphasizing the precision of the Lebanese doctors and the efficiency of the staff. Now, in encountering the limits of AUBMC's care, he lumped AUBMC and the Iraqi Ministry of Health together in the same (im)moral field: "Both of them are the same. They both want money, that's it." Later in the chapter we will return to the theme of the delegation member's critiques of the IMOH-AUBMC nexus.

Returns and Displacements

As Salim's treatment period in Beirut came to an end, they returned to Tuz and immediately found themselves in a city besieged by rival militia groups. *Daesh* was advancing towards the city. Units from the Peshmerga and the *hashd sha'abi* vied for control of Tuz now that the Army had evacuated to confront *Daesh* in Mosul. Over the next few months, Salim's condition continued to improve as he took Lenalidomide capsules. These medications were not available in the state-run hospital and had to be purchased privately in a pharmacy. As Kawa and I drove between Erbil and Sulaymaniyah during the following summer of 2015, he told me: "For us, praise God, we can pay for the medication, but it's difficult. We've sold land, and Salim's income is low

pays it to AUBMC. But some patients require more funds than the allotted amount, even double. Some require much less. We use excess funds from the lost-cost patients to cover the high-cost patients."

because he can't return to the army with that foot." The brothers set up a small window shop that sells cokes and snacks where Salim could sit and make a modest income. With clashes between the *peshmerga* and different militias rocking the city, business was generally slow.

The situation in Tuz continued deteriorating. In 2017 militias under the banner of the *hashd* advanced into nearby Kirkuk and subsequently into Tuz Khormato. The delicate security balance in the city unraveled. Salim, Kawa and the rest of the family were expelled and fled to a small house in Kalar, Sulaymaniyah, where they are currently paying $250/month in rent. Fortunately, Kawa has been able to transfer his work as a teacher to a school in Sulaymaniyah, and he continues to receive a portion of his salary. But overall their economic prospects and capacities to raise funds have been low. Consequently, Salim has yet to return to Beirut for a checkup against the medical advice of local oncologists.

*

Kawa and Salim's story maps out a geography that spans from their home of Tuz in Salahadin, to India, to the northern Iraqi cities of Erbil and Sulaymaniyah, and to Beirut. Government-sponsorship was a temporary condition and represented only a small stint within a much longer treatment trajectory. For Salim and Kawa, private and public stints of treatment overlapped. They began with privately funded chemotherapy in India, followed by state [KRG] oncology in Iraq, followed by federally-funded private oncology in Lebanon, and have (for now) culminated with self-funded pharmaceutical purchases due to the absence of the required drug in Iraqi state-run hospitals. It is not surprising that Salim and Kawa did not consider their status to be fundamentally distinct from the self-

funded patients they encountered in Beirut: The bone marrow transplant was not the first and nor was it the final stop on a much longer treatment journey encompassing various private and public healthcare structures.

Not all cancer journeys to Beirut are routed through conditions of violence and displacement in the manner described above. Patients from the southern provinces of Najaf, Basrah, and Karbala have seen relatively little problems with security since the exit of US troops, and this is largely a result of the fact that the balance of power in Iraq has shifted dramatically in the favor of the Shia political elite based in those provinces. Of the south people often say, "you can sleep in the street." The rise of *daesh* violence never impacted the south directly, but certainly an economic impact was felt. *Daesh* compounded with a drop in oil prices in 2014 drastically impacted the economy, cutting public salaries and tightening already strained budgets. This case details the journey of a patient from Najaf.

Case 3: Leila & Ayman

Like Kawa and Salim, Leila and her brother Ayman participated in the government-sponsored program for bone marrow transplants in 2014. As Leila's *murafiq*, Ayman remained at her side during the in-patient transplant period (approx. 3 weeks), and then they were transferred to a local hotel for 2.5 months of follow up and monitoring. I first spent significant time with Ayman on May 31, 2014 – the day of an unfortunate accident. Just as Leila was starting to recover from the bone marrow transplant and gain the capacity to walk around the hotel, Ayman slipped and fell en route to the hospital from the hotel. He broke his leg. Hobbling down the sidewalk with the

help of another Iraqi *murafiq,* his first move was to visit the office in American University of Beirut Medical Center where the administrator for the Iraqi government contracts was situated. The office was in contact with Ayman almost daily for Leila's appointments and medications, and he knew the administrator Elise well. He was promptly informed by Elise that this problem was not under their purview. He was instructed to go to the division of the hospital were such breaks were handled. Later he recounted what happened to me and others assembled at the Hotel Cavalier:

> "I got to the division. They put me in a room and would not administer a single shot, not a pain killer, nothing until I paid. I said I'd bring the money. It didn't matter. Finally, a friend [another delegation member] brought $450, paid at the accountant window, and they gave me the pain killer. But then they told me the sum for the surgery. It was an unimaginable price. So I went to Najaf for the surgery, and came back the next week…In Lebanon, you'll be treated kindly and generously only if you have money. You buy goodness (*al 'afiya)* with money."

The upper limit of the government program evidenced itself in Ayman and Leila's case earlier and more pointedly than other members of the delegation. From the moment of the accident onward, Ayman used the language of corruption (*fasad*) and thievery (*bowg*) to describe the American University of Beirut, lumping the doctors and staffers into discourses of corruption usually reserved for Iraqi politicians. Ayman was convinced of a kickback system whereby Iraqi Ministry of Health officials received payments from AUBMC as a portion of the funds earned from the lucrative delegation contracts: "It's like this. The Minister or whomever in Baghdad says to the American Hospital. We'll

give you 100 patients, each one at 14 notebooks ($140,000), and you give me 4 notebooks ($40,000) per patient."

Ayman's devastating condemnations of the government program were repeated and generally accepted by delegation members, but they were simultaneously thrown into doubt on the basis of his overt religious fanaticism. He firmly embraced an apocalyptic Shia nationalism that only grew more intense with the sudden rise of *daesh* in the middle of Leila's transplant period in June 2014. Ayman believed that the black flags of *daesh* were a sign of a coming series of battles in which the *mahdi* would eventually be victorious. His legitimate warnings of the corruption and coming disasters of the government program started to blend with his prophetic pronouncements about *daesh* and the *mahdi*, which were regarded as less credible among Shia and Sunni delegation members alike. Somehow the events unfolding in Mosul on television acquired an intense "immediacy" that brought anxieties over *daesh* into Ayman's world in a way that it did not for others (*See* Das 2007: 135-6). Delegation members continued to associate with Ayman but quipped about his "extremism" (*tatarof*) and "sectarianism" (*taifiya*).

His sister Leila was far less interested in talking eschatology and, as her strength returned, became a popular member of the delegation. The route that had led her to Beirut gained the reputation as being among the most circuitous and painful of the delegation members. The journey described below reflects the alternating language of Ayman and Leila over the course of numerous conversations and several years of follow up. Ayman tended to emphasize the technical, logistical, and financial side of the treatment journey, in addition to the navigation of complex social relations whilst traveling for care. Leila tended to focus on the excruciating pain of chemotherapy and side effects, in addition to

the social consequences of treatment back home. I drew together this account of the journey over the course of conversations during the 2014 transplant period, and subsequent follow up visits in 2015 and 2016.

Illness Onset

Symptoms initially arose following the birth of Leila's son in Najaf during early 2013, approximately one year before they would eventually travel to Beirut. "Many things happened after the birth of her son," Ayman often asserted, hinting at his unshakable contention that the child's birth had brought about the cancer. Leila attributed the onset of the illness to the subjection of the southern provinces to intense bombing in 1991: "We were playing in the dust from these materials when we were kids. And also the food in the sanctions was of low quality." This toxic legacy of the country's wars, particularly pronounced in the discourses of southerners, provided a language for excising her son from the disease's etiological web.

As they were already going to an obstetrics and gynecology specialist at the Sadr (Public) Teaching Hospital in Najaf for the baby, they returned to the same physician. The doctor diagnosed "blood shortage." They took 30 doses of an unknown medication to remedy this problem, but there was "no result". This therapeutic futility would repeat itself over and over again. The blood problem only worsened, and Leila's health deteriorated.

A cancer diagnosis came by a fortuitous encounter with a doctor passing through the ward: One afternoon by chance an oncologist named Imaad Sa'bari passed by Leila's bed in the obstetrics and gynecology division. Dr. Imaad suspected that the correct

diagnosis might be leukemia of the lymph nodes. He needed to conduct a bone marrow biopsy, which is not available locally in Najaf. The journey of crossing provincial and eventually international borders began. The doctor referred Leila and Ayman to the lab in the city of Hillah, but a road blockage due to a security issue stalled them for 3 days. Finally, they made it to Hillah. The results proved troubling, Ayman related: “90 percent cancer cells” (*khalaya saratan 90 bil miyyah*). They returned to Najaf with the report in hand. This would not be the first time that mobility revealed the truth of the disease.

Najaf to Erbil

But this truth was immediately thrown into doubt. Leila’s father and uncles were moved but unconvinced about the result in Hillah. The family decided to transfer Leila to Erbil for verification of the result. Leila, her husband Kadham, and Ayman made the trip to Erbil by plane. Their choice was not an uncommon one for Najaf residents. As discussed in the previous chapter, the Kurdish Regional Government’s (KRG) partial independence from the Baghdad-based Ministry of Health allowed Erbil, Sulaymaniyah and Dohuk to invest heavily in oncology from 2003 onward. As many of the "good" doctors of Baghdad had moved to Erbil after the fall of Saddam, the north was often associated with the former standard of care, even among residents of the south. The ‘good doctors’ were not “political” (*siysasi*) or “partisan” (*hizbi*). One such "good doctor" was a man by the name of Ahmed Mashadani. Originally from Baghdad, he fled to the north in 2003. He was responsible for cancers of the blood at Erbil’s Nanakali Hospital. Dr. Mashadani took a look at the report from Hillah. He seemed to confirm Ayman and Leila’s doubts about the quality of examinations, saying, “This report, throw it out

(*dhibo*), I won't rely on it." Nonetheless, the biopsy in Erbil produced exactly the same result as the Hillah test. They returned to Najaf briefly.

It was at this time that Leila's husband left her. Talking about the first segment of the treatment journey often led Leila to convey a sense of rage about her husband's betrayal. But she simultaneously expressed a sense that the matter was minimized amidst the intensity of the treatment process: "We had to decide what to do, and I let my *qahr* go." The family abruptly decided to undergo treatment in Erbil, but they were unclear as to what this entailed. "We had no idea, we planned for a 10-day trip!" Upon arrival to Erbil's Nanakali Cancer Hospital once again, Dr. Mashadani informed them that travel for the next 6 months — until Leila had completed treatment — would be strictly prohibited.

This lengthy expanse of time raised the question of accommodations and residency permits in Erbil, which was no easy matter for Arabs. In order to obtain temporary residence status and rent a house, Ayman would have to obtain a Kurdish "sponsor" (*kafeel*) to represent them before the Kurdish internal security, the *asayish*. Ayman's daily trips to the hospital with Leila afforded him ample opportunity to interact with young Kurdish men acting as *murafiqeen* of patients. One agreed to act as his *kafeel*. Upon receiving approval from the Kurdish Internal Security (*asayish*), they rented a house from a Kurdish man near the hospital. Their daily routine would now consist of multiple weekly trips between the house and Nanakali Cancer Hospital.

Relations with Kurdish neighbors were initially fraught, Ayman emphasized. No one of visited and no one seemed receptive to their presence. Ayman tried to distribute Najaf dates to neighbors but they were not received with warmth. "And Najaf dates are

famous!" Leila inserted. "They seemed racist ('*onsuri*) and sectarian (*taifi*)." Ayman eventually found the source of the problem: The only other non-Kurd on the street, a Turkman from Kirkuk, had been using Ayman and Leila's presence to solidify his own fragile position in the neighborhood, falsely warning the Kurds of Ayman's intentions to move in long-term and purchase property. The Turkman's suggestion was inflammatory. At the time Kurdish politicians were beginning to ratchet up rhetoric against the "Arabization" of the Kurdish north. Ayman decided to visit the Turkman and settle the matter. He brought gifts and insisted that Leila (with her son) have tea with the Turkman's wife. Over the next few days the Turkman evidently backed off his previous position, informing the street that Ayman and Leila were only in Erbil for treatment. "After that our neighbors were very kind to us, which was important, because things were getting very hard," Leila confirmed.

Costs quickly accumulated with the commencement of treatment. During the first consultation, Dr. Mashadani indicated that the full course of chemotherapy would be available (at no cost) in the hospital. This proved untrue. Only one chemotherapy dose was available. They purchased medications from a local pharmacy, the Emir Pharmacy. One gram cost 90,000 Iraqi dinars ($75 USD). And each dose was ten ($750) or 14 grams ($1050). Ayman's capacity to recall the price per gram was atypical (at least in comparison to other research participants) and indicated the immense effort he had dedicated towards itemizing and parsing out costs. They were also purchasing a medication that Ayman could not recall, which was sold for $225 per dose. Each of the five courses called for ten doses. The first of five courses was provided entirely by the

hospital. The second and third were not, and Ayman made the necessary purchases at the pharmacy.

The fourth and fifth courses were partially available: Nanakali provided four or five each time, leaving another four or five for Ayman to purchase. In total they bought 31 doses externally from the pharmacy, mostly at $225 each. With just 5 doses remaining they discovered a cheaper pharmacy offering a dose for $150. This partial provision of public stocks and reliance on outside pharmacies was, according to Ayman, potentially a function of their Najaf residency: "We don't know, but people say that the Erbil patients didn't have to go through this."

Leila's health dropped precipitously towards the end of the eight months of chemotherapy courses in Erbil. She developed ulcers on her skin, a problem that lasted for over two months. Throughout that period they paid for two grams daily of a certain medication that battled the ulcers (at 150,000 dinars/gram or $127 per gram). Leila winced whenever she recalled the pain, lightly rubbing her hands down her forearms. Finally, after two excruciating months, the problem subsided. The ulcer problem had shaken their resolve and their finances, raising doubts among certain family members about the efficacy of treatment. Low on funds, Leila and Ayman returned to Najaf and soon visited Baghdad's oncology center in order to receive a bone marrow biopsy from one Dr. Mohammed Saleem.

The Committee

The visit to Baghdad would prove to represent a major turn in the cancer journey. At the hospital there was a doctor representing the "committee that helps patients with

treatment." He requested some of Leila's tests. They needed to determine whether she might benefit from a bone marrow transplant. But before this process could begin in earnest, Leila's iron started to go up, all the way to 3400, a "number higher than reasonable" (*foq al ma'qool*). So they started to undergo treatment for the iron excess and other secondary problems. They travelled between Najaf and Baghdad several times weekly. The iron levels remained stubbornly high. They decided to return to Erbil to gain a grasp of the problem. They remained in Erbil 15 days. They underwent tests for iron levels and bone marrow. They began to take a drug to remedy the iron — only a portion of which was available for free at the hospital. They returned to Najaf after 15 days, and eventually went back and forth between Najaf and Erbil several more times for the iron problem.

The committee deliberation stalled for months. "We didn't really understand what the committee was, and what they were doing," Ayman reflected. Meanwhile Ayman and his father started sending reports abroad to private hospitals in India, Turkey and Iran for quotes on bone marrow transplants. The hospital in India (through a translator) quoted 90,000 to 100,000 USD. Turkey quoted 140,000 USD. They could not possibly amass such a sum. They were dejected and broke. Ayman reflected: "And you know one reaches a state of despair (*ya's*). You don't know where to go." While the family was making calls and sending reports via whatsapp to doctors in India and Iran, Dr. Ahmed Mashadani in Erbil started making phone calls to Dr. Mohammed Saleem in Baghdad. Dr. Mashadani urged Dr. Saleem to consider including Leila on a government sponsored bone marrow transplant abroad. "This one has to travel, this one has to travel" (*hay lezim titla*'), he would say. Baghdad doctors eventually agreed to push the case to the federal

committee. Representatives of the aforementioned committee requested tests, and then more tests. Twice Ayman and Leila went to Erbil to obtain them, not wanting to risk local technical inaccuracies and/or politically motivated manipulations of the results on the part of Baghdad care providers. The three private hospitals abroad contracted by the Iraqi Ministry of Health would only agree to take Leila's case if the indicators for a bone marrow transplant were verifiably favorable. This was a bilateral decision, and Ayman wanted to remove the Iraqi side from the medical equation as much as possible.

The committee's decision finally came. They received a call from Dr. Mohammed Saleem during their second trip to Erbil for examinations: They had been assigned to Beirut for a bone marrow transplant. They were told that the Iraqi government contracted the American University of Beirut for the administration of the transplants and paid the hospital $140,000 USD per patient with an allowance for one *murafiq (*companion) per patient. Wanting to ensure the decision was not reversed, Ayman and Leila drove quickly to the Erbil airport, arrived to Najaf by 1pm, and subsequently landed in Beirut by the evening. They could not leave anything to chance. Ayman noted: "If we didn't get there quickly, maybe her indicators would change and we'd have to come back to Iraq for more treatment."

They arrived to their assigned hotel (the Cavalier Hotel in Beirut), and found themselves with a cohort of 10 other patients from across the country, each accompanied by a "companion" (*murafiq*), including Kawa and Salim (previous section). The hotel receptionist informed them that an administrator from the American University of Beirut Medical Center would contact their rooms with appointment times within 24 hours. With these logistics taken care of, for the first time in a year Ayman was granted the prospect

of taking an evening to relax. I was just starting to conduct research at Cavalier at the time, and I met Ayman as he was getting settled. Going forward, whereas most *murafiqeen* (companions) hung out in the evenings, I experienced great difficultly locating Ayman. Ayman conceived of his role as distinct from that of the other *murafiqeen* along gendered lines: "My role is different from the other *shabab* (guys) in the hotel. They are all here with whom? With their brothers and fathers. They can go out and get a change in environment. For me, I can't. Where she goes, I have to go." Indeed, most of the other patients in the delegation of ten were male, and in Ayman's view, their companions enjoyed considerable freedom socially outside of scheduled appointments. The notion of *murafiq*-as-protector of female honor and safety kept Ayman isolated from the rest of the group. He remained at Leila's side. I only came to know Ayman well when he broke his foot and was forced to rely on the assistance of other delegation members.

Again, the neglectful stance of the hospital towards his foot injury was the moment when he turned on the American University of Beirut and began protests of corruption and neglect. [54] "They don't care about the patients. They're commercially oriented. That's it. You give them money and they give you treatment." Despite Ayman's disdain for the government program and the corruption he alleged it represented, the therapeutic results of the high-tech intervention were undeniable. Leila responded

[54] Some readers have noted a resemblance between the bone marrow transplant program's (mis)usage of the labor of the *murafiqeen* and Wool and Messinger's (2012) study of the Non-Medical Attendent Program (NMA) at Walter Reed, a program in which a designated family member receives compensation for assisting wounded soldiers. I see mostly contrasts between the two accounts. The critique of Walter Reed among the NMA's is a result of the overbearing presence of military norms and guidelines, and the disconnect between the priorities of the military and families. Here the critique is far more devastating. Ayman suspects that the whole bone marrow transplant program was engineered for the purpose of kickbacks and profit benefitting both Iraqi and Lebanese functionaries.

magnificently to the bone marrow transplant. All indicators pointed in the right direction. She regained weight. She experienced no major side effects. She spoke of the possibility of returning to the classroom as a teacher.

Long-term Recovery and Expenses

Leila and Ayman returned to Najaf after the 100-day treatment period. Leila was reunited with her son. Unbeknownst to Ayman and the other members of the family, the follow up would require long-term expenditures, none of which would be included on the government contract. Two years later in 2016 I met with Ayman and Leila in Beirut. They told me that each packet of sprycel contains 60 pills and costs $4100, lasting two months. She consumes six packets per year. They can only be purchased in Lebanon, generating extra costs of travel back and forth. The kinship network has been pushed to their limits financially, forcing them to modify the treatment plan. Ayman noted: “We should be coming here four times a year to buy medications and perform a checkup. But you know it’s not easy to come here. We can’t muster enough money for more than two visits. At the beginning we had a plot of land. We sold it, and we spent it. Now we are taking on debts. The doctor prefers four examinations per year, but we can only do two." He broadened the issue to the situation in Iraq as a whole: "It's a tired situation in Iraq. Everyone is weary, and so you can't ask for too much help. In the beginning yes, but not after." This discourse of drained wider social networks was a commonly issued complaint among patients and their companions. The social nets normally in place for the raising of illness funds were no longer in place, particularly after a disease had extended into a chronic one.

Out of pocket costs accumulated within a fractured public system across Iraqi hospitals, and then were compounded through a narrowly conceived government-sponsored treatment abroad program. The accumulation of expenses and the eventual modification of the treatment plan indicates a complex negotiation of compromises. How the kinship network went through a process of determining that two annual Beirut check ups sufficed instead of four is beyond the scope of the paper. I am also not privy to the household dynamics involved in the management of their enormous debt. When I asked Ayman privately about the extent of their debts, he made me promise not to tell Leila. I nodded and assented. In a characteristically precise fashion, he did not give me a generic number like "3 notebooks" ($30,000). He said pointedly, "We are $42,000 in debt." As a family of painters and teachers, the sum would not be diminished any time soon. He worried that Leila's knowledge of the enormous debt would drain her "immunities" and capacity to ward off the return of the disease. They were caught in long-term payments that certainly amounted to what Xu et al. (2003) would call "catastrophic health expenditures," and yet somehow they would find ways to shield Leila from this reality.

Situated in the broader context of a treatment journey, the government-sponsored bone marrow transplant appears as a mechanism providing temporary but insufficient relief. The last time I saw Ayman and Leila it was September of 2016. First we stopped by one of the pharmacies to pick up a medication for their father back home, and Ayman doled out $200. *Bowageen* (thieves), he whispered loudly. Leila heard the exchange and smiled. As we walked from the American University of Beirut hospital down the hill towards to the water, I was amazed at Leila's agility and energy. The pair urged me to

visit Iraq during the *'arbayiniyah*, an important Shia holiday involving a huge procession to the city of Karbala. Ayman noted:

> Ayman: Mac Lord willing you'll come in November during the Arba'iniya, you'll see how the people serve you (*ykhdimak*). Food for every person. With no money. It's a miracle, I mean, you can't understand how such a crowd (*heych jumhoor*) is comfortable.
>
> Leila added: In Saudi hundreds die every year but you don't have this in the *Arba'iniya*. And the roads are very narrow I mean. But nothing bad happens in the *arba'iniya*.
>
> Ayman finished: "There are narrow roads and sewage pipes fit for 2 million, and there are 20 million pilgrims. It's a miracle by God. We don't know from where it comes. They do it every year and there are more people."

The kind invitation was, I think, Ayman and Leila's way of expressing that there are still places where a boundless, unlimited generosity reigns, where the logic of both *bowg* (thievery) and time-bound government coverage is undone.

Discussion

The Iraqi state's transnational oncology programs constitute ephemeral extensions of state welfare across borders. These government contractual arrangements arise and dissolve, leaving no trace of their existence except for the struggles of former participants to piece together follow-ups. The bone marrow transplant soon disappeared after less than a year of operation, and funds quickly shifted to the "heroes" (*abtal*) fighting against *daesh* and suffering from war-related burns, blasts, and other injuries. Instead of the

Beirut oncology centers, the plastic surgery divisions now saw the bulk of the government funded patients. One Beirut-based specialist explained the Iraqi government's decision as simultaneously medical and financial: "You could spend all of Iraq's healthcare budget on one leukemia or breast cancer patient!" Here we see the particular precariousness of cancer as a temporally expansive set of diseases intersecting with judgements around the state's cross border priorities.

A long-term analysis of patients' trajectories of care-seeking reveals the 100-day bone marrow transplant period as a fleeting moment within a broader tapestry of combined public and private health care institutions. Taken over the course of a multiyear period, the 100-day bone marrow transplant loses its appearance of comprehensiveness. Seen from this wider temporal expanse, the struggles facing the state-funded patients appear remarkably similar to those who have never received such support, namely, the myriad difficulties of marshaling resources and accessing care under conditions of war. The apparently stark contrast between self-funded and state-funded care breaks down.

The ephemerality and insufficiency of the program was neither fully apparent nor was it entirely removed from the field of awareness during the 100 day transplant period. From the moment of arrival to Lebanon, pervading the discourse of delegation members was a sensibility that something was amiss. Towards the completion of the 100 days, these doubts solidified into a more pointed critique of the state as sacrificing long-term reconstruction in Iraq for the sake of quick contracts abroad that could keep corruption and kickbacks under wraps. Finding themselves amidst vast but fleeting state resources at the margins only solidified disappointments about their absence at the center – i.e., Baghdad, the historical center of oncology in Iraq.

The essay responds to Poole and Das' (2004) call for ethnographies that explore the state as "embedded in practices, places, and languages considered to be at the margins of the state" (Poole and Das 2004: 3). In turning to margins and peripheries, they explore how anthropology is uniquely situated to trouble the assumption that the state is a "rationalized administrative form of political organization that becomes weakened or less fully articulated along its territorial or social margin." In this chapter, at the margin we find high-tech medicine, comprehensive services, and the expenditure of immense government resources per capita. But this buildup of state oncology resources proves to be a mirage – and the participants in the program possess a suspicion of this illusion long before they are able to articulate it in the form of a political critique.

Particularly for self-funded patients like Um Amir for whom costs accumulate quickly and disastrously, we are left with a sense that the value and benefit of high-cost cancer treatment across borders can only be grasped in terms of the hopes invested in treating or at least assuaging overlapping chronicities. Um Amir desired a context of care where the medicine would be "precise" and where her *qahr* over the loss of Amir would be met with appropriate responsiveness, albeit fleetingly. The chronicity of the disease converges with the suffering of life under war, a "suffering of an ongoing, chronic, and enduring character" (Buch-Segal 2016: 10). Um Amir shows us that our notions of the benefit of high cost treatment can only make sense if we grasp the temporal, social, and physical depth of the wounds present in the scene of care.[55]

[55] See Dewachi (2015) for a discussion and theorization of the "wound."

Conclusion

Anthropologists have shown how cancer is a "transnational phenomenon" that draws upon and generates inequalities between the global north and south (Burke and Mathews 2017), but less attention has been paid to the ways in which cancer travels across regions and generates transnational geographies of care through the journeys of cancer patients. These cases highlight the fact that the growing phenomenon of itineraries between Iraq and neighboring countries for oncology places enormous strains on kinship networks. Earlier anthropological engagements with international therapeutic itineraries have called attention to the massive inequalities that generate care-seeking trajectories across borders in the Middle East and beyond, and the resulting financial burdens placed on families (Kangas 2010; Inhorn and Patrizio 2010); however, these studies have yet to analyze how wars in the region have generated and shaped such trajectories. One significant product of the 2003 invasion and subsequent occupation has been a redistribution of care-seeking pathways across borders, forcing families and communities to negotiate the financial losses of war while also confronting the additional expenses of private health care abroad. While kinship networks enable the cobbling together of resources and information, the highly contingent character of the care-seeking journeys for both privately and publicly funded patients alike speaks not only to the uncertainties of chronic illness but also the difficulties of navigating health care under conditions of war. Ongoing conflict in Iraq has produced violent evictions from homes, transformed household budgets and income generation strategies, and crippled public health care institutions. These conditions will continue to unfold in unpredictable ways.

The present chapter has revealed the accumulation of costs and expenditures over the course of a treatment journey; however, it has not attempted to explore with any great detail the mechanisms and networks through which funds are raised. This requires a different set of methodological tools. Whereas this chapter has drawn from interviews, conversations, and periods of accompaniment with patients and their companions in Beirut, the following chapter will take us into kinship and neighborly networks from which such journeys originate and gather resources

CHAPTER THREE

Mobilizing Resources Amidst Displacement

Abu Samir is a farmer in his 40s from Salahadin, Iraq. I first encountered Abu Samir in Beirut during one of his stints of radiotherapy. It was August 2014, just two months after the *daesh* takeover of Mosul and subsequent spread into areas of Salahadin. From his bedroom in Beirut's Hamra Star hotel he showed me pictures of his home, his house and his farm along the Tigris River. As we sat and drank tea, he occasionally took calls from brothers and nephews about his crops in Salahadin. Their hometown of Yathrib was still removed from the intensifying fighting, and they continued agricultural labor. Sitting in the Beirut hotel room, I did not anticipate that I would spend the next three years following his journey for care and eventually residing with his family in Iraq.

More than two years after our first encounter, I was sitting with Abu Samir in his Erbil home. It was the summer of 2016. Displaced northward from Salahadin by militias in the winter of 2014, he now resided in a small structure on the property of a Kurdish landlord for whom he worked as a tenant farmer. It was a frigid winter day in Erbil. Ever since the end of the summer harvest, few kinsmen outside of Abu Samir's household wanted to visit him. The costs of his cancer treatments in Beirut had gradually drained the resources of his broader kinship network, a network spread across three households. The three households were already struggling economically as "displaced persons" (*naziheen).* Two years had passed since the violent expulsion from Yathrib at the hands of

the *hashd sha'abi* (Popular Mobilization Forces) militias.[56] Three years had passed since the onset of Abu Samir's illness. As tenant farmers in the Kurdish north, supplementary resources for the sake of cross-border treatment were extremely scarce. Making the question of resources more fraught still, the reality of Abu Samir's illness was now in question. His hair had grown back following a break in chemotherapy. Some kinsmen murmured that he no longer appeared to be "tired" (*ta'ban*), "sick" (*mareedh*), or "between life and death" (*beyn al hayah wil mout).* Cross-household payments towards his "collective" (*jama'iyah*) became slower and scarcer. Visits dwindled. He was gradually losing ground in the effort to mobilize resources towards his treatment. I sat with Abu Samir alone.

A few days later, Abu Samir received a phone call from a farmer who had recently passed through Yathrib. The farmer conveyed troubling news: "Abu Samir, they destroyed (*falasho*) your house." Whispers of the culpability of militias, particularly the League of the Righteous (*Asa'ib ahl al* haq), and the betrayal of former Shia neighbors in allegedly abetting them, circulated across the kinship network. Sympathies were directed towards Abu Samir on the basis of his vulnerable state as a sick man. His younger brother Abu Haamid, who was typically the most reluctant to recognize Abu Samir's illness and contribute payments accordingly, wailed on his brother's behalf: "By God they knew Abu Samir was sick. They knew it, because the neighbors and the militias are working

[56] As stated in Part I, in Part II my descriptions of complex violent events largely rely on the articulations of individuals. The representation of these events makes no claim to reveal 'what happened' but rather the ways these events were told in everyday talk and account-giving in the particular context where I conducted fieldwork. In the final part of the current chapter, I show how these accounts of violent events may change and vary across the kinship network.

together. They knew it and still burned down his house!" Over the next two weeks Abu Samir received visitors and offers of cash for his continued treatment in Beirut. He simultaneously received offers of deferred payments from his Kurdish neighbor and landlord. Abu Samir became acknowledged as robustly and legitimately "sick" (*mareedh*) once again – not on the basis of changes in symptoms but on the basis of his house's destruction 400 kilometers away. This was just the latest of numerous instances in which the ongoing war was drawn into the logics of giving or withholding financial support for Abu Samir's illness journey in ways that I could not have anticipated.

Not long after the destruction of his home, I accompanied Abu Samir to Beirut for a checkup. He paid approximately $1,700 for a PET scan, lodging, and flights. He was asked by his oncologist in Beirut how it was that he managed to pull together upwards of $90,000 despite the loss of his home and fields during displacement. Abu Samir replied in his characteristically vague manner: "We brought [money] from here and there (*njeeb min hinna wa hinna*), from relatives and neighbors (*min qaraib wa jiran*)."

The terse statement stuck with me given that I had witnessed years of struggle and negotiation around this very issue. As the opening of a two-part ethnography of Abu Samir's cancer journey, this chapter will explore how Abu Samir mobilized a network amidst the various displacements of sectarian violence and illness. Examining three different epochs in Abu Samir's journey, I show how the kinship network moves through justifications for either granting or withholding resources. Amidst war and displacement people do not have sufficient access to context in order to formulate or forecast these justifications in advance. Consequently, any attempt to understand such logics requires

careful ethnographic elaboration within the encounters, sites, and struggles in which they take shape.

*

How do cancer patients mobilize mass resources across a kinship network amidst displacement? In refugee and displacement studies, one finds considerable attention to the post-displacement dynamics of finances and income generation. Korf (2004) lists dozens of "livelihood strategies" of displaced households and kinship networks, including "reorganizing and regrouping the family according to security and economic needs," "working in fields in groups and "seeking refuge in the wider family network" (Korf 2004: 286). Kinship networks piece together "displaced livelihoods" in order to reconfigure income streams in new sites of residence (Amirthalingam and Lakshman 2009). These studies tend to assume that "families" and kinship "networks" are coherent social bodies that collaboratively strategize alternative livelihoods amidst the myriad hardships of displacement. The studies do not allow for the possibility that kinship networks might themselves undergo processes of transformation and dislocation, or that certain actors within a kinship network may be displaced or dislocated differently than others (Das 2000). In Abu Samir's case, displacement resulting from sectarian violence convergences with the displacements of cancer. He is both "displaced" (*nazih*) and a sick man "between life and death" (*beyn al hayah wil mout*). At times he is acknowledged as occupying these subject positions, therefore garnering the support of his kinsmen, and at other times this acknowledgement is deflected or denied.

The chapter is broken into three segments aligning with three periods in Abu Samir's journey. (1) In the first section "Leading up to Eviction (2008 – 2014)," I will

examine the war-related conditions already facing the three households prior to displacement, and subsequently I track the kinship network's violent expulsion from their homes and journey north in pursuit of secure residence. Amidst this displacement journey, cross household gift-giving and performances of support towards Abu Samir's illness remain in place. (2) In the second part "Settlement in Erbil (2014 – 2015)," I examine the establishment of tenant farming arrangements in Erbil. As resources are stretched amidst a shifting political economy of tenant farming, Abu Samir's position in the kinship network is rendered more vulnerable. Justifications among brothers and nephews for withholding cross-household payments gain momentum. (3) In the third section "Preparing for death (2016 –)," I examine a period in which Abu Samir becomes convinced of his quickening demise and he makes preparations to secure the financial and political security of his household. These hurried efforts corrode relations with key members of the kinship network. Isolated, Abu Samir places his economic security in augmenting the productivity of his household farm, heightening the stakes of securing strong commercial relations with the Kurds. During this period, the aforementioned destruction of Abu Samir's household in Yathrib brings the kinship network back into a supportive posture, but only for a time.

Leading up to Eviction (2008 – 2014)

Before examining the onset of the illness and process of displacement, it is important to grasp the already shifting political economy of Abu Samir's household prior

to their eviction.[57] Abu Samir and his brothers farmed three separate plots of grapes along the Tigris River in southern Salahadin during the 1990s and 2000s. A catastrophic ecological shift transpired across their area beginning in 2008: The arrival of American troops to the rural region along the Tigris had gradually introduced a number of foreign pests, one of them known as the "American mosquito" (*al duda al amrikiya*). This pest was so uniquely resilient that the strongest local pesticides could not annihilate it. Hundreds of thousands of grape trees in southern Salahadin rotted and died. Over the course of five years, Abu Samir and his brothers were compelled to uproot their grape trees and plant ordinary field crops such as tomatoes, onions, cauliflower, watermelon, turnips, eggplants, and cabbage. The shift from grapes to field crops transformed the local political economy and division of labor. Whereas the labors of grape tree cultivation were concentrated around two annual clusters of months, the labors of field crops were daily and constant.

This intensification and expansion of labor across the calendar year resulted in new allocations of roles. Female household members – formerly chiefly responsible for child rearing and non-agricultural tasks – would now also be needed on a daily basis for planting, harvesting, and cleaning crop lines. Children over the age of 10 would also have to work in the fields and lessen their studies. The grown men would oversee and occasionally work the crop lines, and they would take responsibility for transporting produce from the fields to the market in Baghdad multiple times daily. Instead of traveling to market only during the harvest periods to sell grapes, now trips had to be

[57] This section and the chapter as a whole draws inspiration from Tamari's (1981) brilliant study on changes in the Palestinian agricultural household.

made everyday of the year other than Fridays. Driving to market on a daily basis and presiding over the sale of one's produce was now central to the duties expected of a household head, in addition to monitoring crop lines and checking the nozzles, irrigation pipes, etc. (These shifting labor dynamics on the farm will be discussed in greater detail in chapter 4.)

The post-2003 elimination of agricultural subsidies meant that all costs arising from the response to the sudden sickness and eventual death of their grapes drew exclusively upon family resources. The massive amount of fertilizer needed to address the "American mosquito" was purchased at full price on personal funds. When they ultimately decided to uproot their grape trees and switch to field crops, again the significant startup costs associated with farming a new set of crops fell squarely on Abu Samir and his brothers. They needed to purchase seed, tractors, hauling vehicles, tarp, and additional irrigation pipes. They enjoyed longstanding credit agreements with local vendors in Salahadin and nearby Baghdad, but these vendors were hesitant to extend significant credit lines when such a large portion of the local farmers were experiencing similar duress.

Illness Onset and Initial Gifts

Still in Salahadin, Abu Samir's illness emerged in early 2013. The pursuit to understand the blocked sinus (*jiyoob anfiya*) thrust Abu Samir across an expansive geography: Yathrib, then Baghdad, then Kirkuk, then Erbil, and finally Beirut. At the time of the illness onset, Abu Samir's oldest son was 13 years of age. This presented a problem in terms of fulfilling essential head of household duties in Abu Samir's absence.

Abu Samir's older brother Abu Umar, 47, provided two of his grown sons to cover the gaps, one son to drive Abu Samir to various clinics and another son to take over daily hauling/selling duties in the market. The arrangement enabled the continued economic viability and separation of the three households. Once Abu Samir received a definitive cancer diagnosis in Erbil and was informed of a 3-month wait for public treatment, his older brother Abu Umar insisted upon his acquiring private treatment in Beirut and offered $5800 USD as an initial sum in support. Abu Haamid, the younger brother, offered a sum of $3200 a few days after Abu Umar. The presentation of these funds was accompanied by the typical assurances diminishing the importance of money and elevating the life of the sick man, such as: "Money isn't anything, the most important thing is the life of the human." Another commonplace assurance, "There is no difference," (*mako faraq*) fell from the lips of several relatives and visitors. The phrase is intended to convey the lack of distinction between the accounts of separate households.

The initial donations of money given to Abu Samir after cancer diagnosis bore the highly ambiguous character of gifts: The terms of repayment for the $5300 from Abu Umar and the $3200 from Abu Haamid, if expected at all, were left vague. As Firth (1959) notes in his discussion of gifts, the dynamics of payment and repayment – gift and counter gift – should not be confused with formalized debt/credit: "Barter implies some agreement as to the rates of exchange…[With gifts] no stipulation was made by the donor as to the amount of the commodity which must be given in exchange, and no bargaining or haggling of any kind took place" (1959: 410). At the very most, Firth's Maori would subtly drop hints about the desired timing and nature of the return, but these hints had to remain vague. The sums of $5300 (Abu Umar) and $3200 (Abu Haamid) paid to Abu

Samir bore this highly ambiguous, gift-like status. Whenever I asked about the return of these initial payments, Abu Umar or Abu Haamid would all say in various ways, "By God (*wallah*), money is not important, we don't know. We'll see" (*nshouf*).

Treatment and Displacement

Traveling to Beirut for chemotherapy and radiotherapy, Abu Samir grew accustomed to a back-and-forth movement between Iraq and Lebanon. It was during these initial itineraries that I met Abu Samir for the first time near the American University of Beirut Hospital, and subsequently began a five-year relationship that remains to this day.

As Abu Samir finished a month of radiotherapy in Beirut in the fall of 2014, he expressed concern over returning home to Salahadin. The rise of *daesh* was gradually overtaking the province. He feared his hometown in the rural outskirts of Yathrib was next. Two months later Haitham and Abu Samir called to inform me that, in their words, militias under the banner of the *hashd sha'bi* (Popular Mobilization Forces) as well as the *asa'ib ahl al haq* (League of the Righteous) had expelled them from their lands. They said that these militias cleared Sunni families from the mixed areas of Salahadin, accusing the local Sunni population of "embracing" (*hathina*) the *daesh* uprising taking over the province. Haitham spoke with exasperation over the phone, "*Daesh* was not in our area. They were in the town of Yathrib but not the surrounding area where we are. But the militias they were saying, 'you are all *daesh'*. What? Why?"

During the confused process of fleeing from their hometown of Yathrib, the eldest of the three brothers Abu Umar went north. He now found himself stuck in a blockaded

area near Mosul with a portion of his household, subsequently crossing into Turkey via smugglers. The households of Abu Samir, Abu Haamid, and the majority of Abu Umar's sons and daughters first attempted entrance into the Kurdistan Regional Government — both at the Erbil and Sulaymaniyah entry points — but were denied. The KRG closed ground entrances to most non-residents following the rise of *daesh*. They could not travel directly south to Baghdad for fear of abduction by the PMF. With northern and southern routes blocked, they managed to make it to Baghdad via a multi-day circuitous route through Kirkuk, Syria, Karbala, and then Baghdad. Abu Umar's separation from the broader group placed his household temporarily in the hands of his eldest remaining sons Uthman (33 yrs.) and Haitham (28 yrs.), raising the question of Abu Samir's access to resources from this branch of the kinship network. The question was whether Abu Umar's fierce commitment to Abu Samir and desire to support his treatment would carry weight among his sons in displacement.

For now, it appeared that Abu Samir would continue to receive the consistent support of Abu Umar's household through Haitham's diplomacy with Uthman, the head of household in Abu Umar's absence. Haitham continued to make pharmaceutical purchases on Abu Samir's behalf in Baghdad, while keeping in touch with his contacts in Beirut to arrange future appointments. Haitham articulated his continued labors on behalf of Abu Samir as the extension of an intergenerational friendship between his uncle Abu Samir and his father Abu Umar – a bond that was not shared with Abu Haamid. The two elder household heads enjoyed a longstanding "friendship" (*sadaqa*) and a "strong bond" (*miyana qowiya*) predicated on exchanges of gifts and women.

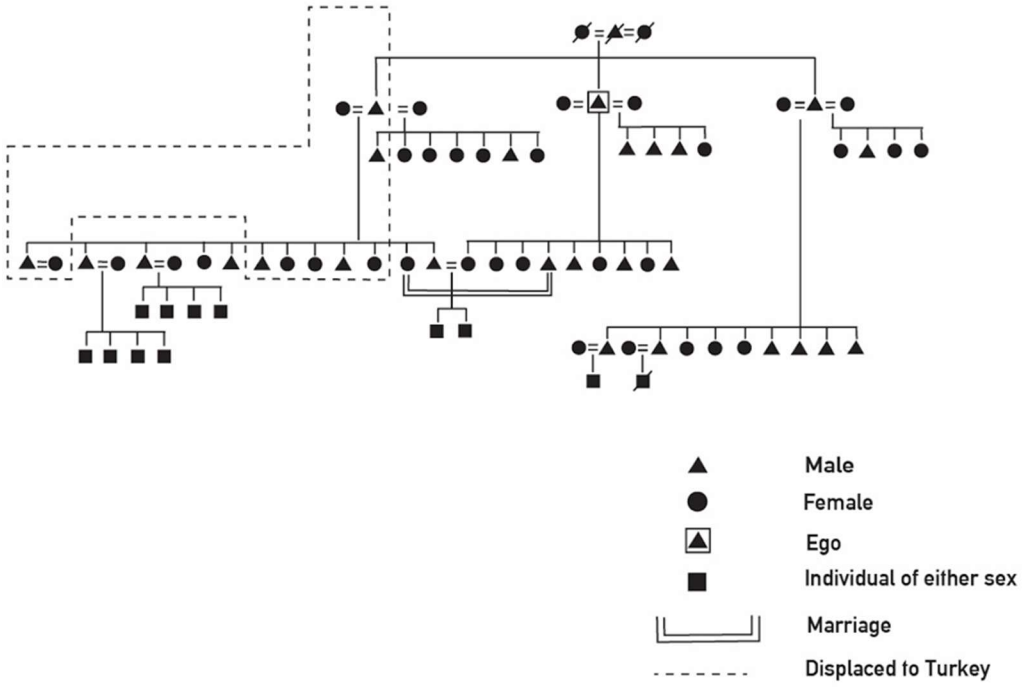


Figure 3.1: The Three Households | Left to right: Abu Umar/Uthman; Abu Samir (ego); Abu Haamid

I do not understand *sadaqah* in the manner that Eickelman (1989: 140) describes bonds of *qarabah* (closeness) among households and groups of households. *Sadaqah* describes a bond between individuals and lacks the corporate, semi-contractual sense of *qarabah*. Not all of the sons of Abu Umar shared Haitham's sentiments of affinity towards Abu Samir. Uthman, the head of household in displacement, rarely visited Abu Samir and instead preferred the company of the younger uncle Abu Haamid. As the displacement journey unfolds, we will see how Uthman's posture towards Abu Samir shapes flows of cash towards his ailing uncle. But for now Uthman fell in line behind his father's position. Over the phone Abu Umar would remind everyone that Abu Samir was "between life and death" (*beyn al hayah wil mout*) with a "serious disease" (*maradh khateer*). The material implications were clear.

Residing in Baghdad

As they arrived to Baghdad, temporarily the three households (now led by Uthman, Abu Samir, and Abu Haamid respectively) lodged with a man named Mohanid, a wealthy Baghdad resident whom Abu Samir had initially encountered in the waiting room of the American University of Beirut Medical Center. “If not for treatment in Beirut, we would have had nowhere to stay,” Haitham reflected. Abu Samir’s illness journey unexpectedly provided a valuable tie outside of their kinship and agricultural networks. The framing of illness as strictly a family affair is a common feature of scholarship on illness support structures in the Arab World (al-Mutlaq and Chaleby 1995; Hamdy and Nasir 2008). Such a framing does not hold in a context of war and mobility, where a variety of non-kin relations are drawn into a treatment journey.

The arrangement with Mohanid was temporary, however. Soon the three households packed into a single rented house ($200 per month rent). Financial duress quickly became acute. Reliable income generating possibilities were scarce. Abu Samir explained: “The young boys were selling Kleenex in the streets of Baghdad, they’d come back with 2000 dinars every day (less than 2 dollars).” The continuation of Abu Samir’s treatment presented an additional budgetary problem. His Beirut oncologist had already designated the need for a follow up CT or PET scan.

At this juncture, each of the household heads agreed that attempting examinations in Baghdad’s hospitals would be an exercise in futility at best and dangerous at worst. They understood Baghdad hospitals as “political” (*hizbi*) or “sectarian” (*taifi*). Considering the perceived politicization and militarization of care in the capital (*See* Dewachi et al. 2014; Fouad et al. 2017), no one overtly raised objections about the need

to continue Abu Samir's treatment in Beirut's private oncology centers. The question became one of how to raise funds amidst the depressed earnings of displacement. Each of the three households had lost heavy machinery and trucks while fleeing from Yathrib, removing the possibility of collecting quick cash through equipment sales. The household heads reported meager cash savings. Uthman reported $3500; Abu Samir had $2000; Abu Haamid had $4000. Haitham worked to ensure that some of the remaining sum could be directed towards his favored uncle's treatment. He arranged a collective (*jama'iyah*) from Uthman and Abu Haamid's coffers.

Baghdad to Erbil

The lack of income in Baghdad compelled Uthman, Abu Samir, and Abu Haamid to consider possibilities in other regions where, they speculated, it might be possible to arrange a tenant farming agreement. Over decades of hauling and selling produce to different markets throughout the northern provinces of the country, they had developed close ties with farmers in Mosul, Erbil, and Kirkuk. They surmised that only Erbil could, at this particular moment, guarantee security and ready access to agricultural networks due to the presence of *daesh* and/or militia groups in other locations. After just two months in Baghdad, they started making calls to contacts in Erbil. They contacted Kurdish farmers from Erbil as well as Arab farmers from Salahadin already displaced and working as tenant farmers in the Kurdish north.

After days of calls, they were connected with one of the heads of the Erbil farmer's market. The man was a Kurd with fluent Arabic, and his family (like many Kurdish merchants) had supported Saddam's regime up until the Kurdish uprising of

1991 when political tides turned towards local, autonomous rule. On the one hand he was sympathetic to the current plight of the displaced, and on the other he sought to play the profitable role of mediator between local Kurdish landowners and incoming agricultural laborers. Over the phone he told Abu Samir that many Kurdish farmers were looking for tenant families among the "displaced" (*naziheen*). If they came to Erbil, he would facilitate introductions with potential Kurdish landlords. They would retain the final say on selecting the plot of their choice.

Concerned about the timing of treatment and the need to raise funds, Abu Samir insisted upon taking action quickly. His *murafiq* Haitham supported his position. Abu Haamid and to a slightly lesser degree Uthman wanted to proceed more cautiously given the unpredictability of land negotiations in Erbil and the high upfront costs of travel. Traveling north by road was out of the question due to the presence of militias along the northbound highways, and the fact that the KRG now restricted ground entry points and rejected non-residents lacking KRG connections. Plane travel was the only option, and a one-way Baghdad-Erbil flight would cost $200 USD per head. In the end, Abu Samir's position became more palatable as conditions in Baghdad worsened. Uthman also needed to establish income generation quickly in order to enable cash transfers to his father Abu Umar now residing in Turkey.

The household heads reached a compromise and decided to migrate in waves. Abu Samir would take his household first, accompanied by his longtime companion Haitham. Abu Samir would establish a tenant contract with a Kurdish farmer. Ideally they would find a plot where other potential landowners were in search of tenants. Then, if conditions proved adequate, Uthman and Abu Haamid would migrate their households.

For Abu Samir, an added benefit of moving to Erbil promptly would be direct access to an airport with daily flights to Beirut, where he would continue to undergo treatment. At this point in the journey, all male household heads remained in favor of this eventuality: Abu Samir was "sick" (*mareedh*) and merited continued support. Would the performances of these assurances continue amidst the long-term span of displacement?

Settlement in Erbil (2014 – 2015)

Throughout this process of eviction and sojourn northward, I remained in touch with Abu Samir and Haitham over the phone but did not see them in person. The decision of the household heads to move to the relatively secure province of Erbil, the capital of the semi-autonomous Kurdish region, afforded me the opportunity to conduct fieldwork with Abu Samir and his kinship network. After a one-year hiatus since our initial meetings in Beirut, I received repeated spirited phone calls from Abu Samir and Haitham urging me to visit Erbil: "*Yallah* Mr. Mac, we are displaced and have no one visiting us!" Haitham joked that he would gladly "write the report" I was completing. Though it was not uncommon for me to receive invitations to visit from the Iraqis I encountered in Beirut, this time I was already planning a visit to Erbil's cancer hospitals. I accepted.

I landed to Erbil's airport and Haitham awaited in the parking lot with a KIA flatbed truck full of agricultural products. We drove southeast for an hour towards the farms situated along Erbil – Kirkuk border. Upon arrival to Abu Samir's tenant farming plot, the members of the other two households were nowhere in sight. "That's Abu Haamid's house, the one by those trees," Abu Samir pointed to a structure in the distance. Sticking as close as possible to the organization of families in Salahadin, the three lines

had indeed managed to set up separate, independent plots in Erbil. Abu Samir and his wives and children farmed an 80-donum plot owned by a Kurd named Kak Hashyar.[58] Approximately 500 meters down the eastward dirt road, Abu Haamid's family farmed a 45-donum plot owned by a Kurd named Kak Farhad. Another three kilometers east, Uthman and Haitham co-led the farming of a 35-donum plot owned by a Kurd named Kak Kawa.

The Ditch

The main reason for the easy availability of three plots in such close proximity to one another was their highly precarious location: The plots were situated in the borderlands of Erbil and Kirkuk within a few hundred kilometers of the Erbil checkpoint, marking the outer edge of the KRG. Many of the Arab "displaced" (*naziheen*) did not want to farm in the borderlands for fear of excessive interactions with Kurdish *peshmerga* soldiers. The borderlands had recently received physical definition: The Kurdish Regional Government responded to the rise of *daesh* by digging a 5-meter wide ditch (*hufr*) for hundreds of kilometers around the perimeter of Erbil (physically marking separation between the KRG and federal provinces). Strikingly, the ditch ran along the edges of the three plots farmed by Abu Samir and his brothers. They were farming on the physical extremity of the KRG, just a few meters from the federal provinces from which they had been violently evicted. The men of the three households would constantly reference the *hufr* when addressing the question of long-term inhabitation in the KRG: "If we rent or buy land here, one day they can just come and say, *yallah* out! And toss us

[58] *Kak,* a Kurdish honorific, translates roughly to "Mr." or "sir".

over the *hufr*." As a practical matter, the *hufr* posed a daily danger. The women constantly had to caution the kids against playing on the ditch's spoil bank. They wanted to protect the kids from falling, and to avoid scolding from the *peshmerga* soldiers based at a nearby lookout tower.

In addition to the undesirable *hufr*, the plots were also flawed in their lack of proximity to town and city centers. Separated from Erbil city and the main farmer's market by 50 kilometers, the closest intermediary town was Qoshtapa (25 kilometers). Qoshtapa's economy was largely driven by a UN-funded camp for Syrian-Kurdish refugees. Qoshtapa was the closest location for basic purchases, rudimentary pharmacies, and groceries. But selling their product required trips into Erbil city. A constant interchange between farmland, town, and city is crucial for understanding Middle East agriculture (Rabo 1986). The men of the three households shuttled between the farms, Qoshtapa, and Erbil city on a daily basis. These everyday mobilities were constant and constituted a large part of male roles.

Tenant Farming

Arriving to Erbil province before the other households, Abu Samir's decision to move forward with these poorly situated plots was largely a function of his pressing treatment-related financial needs. He spent $2500 on average per chemotherapy trip to Beirut, and much more for more complex procedures. Abu Samir sought out an unusually large plot in order to offset the effects of the 50/50 split between tenant and landlord. Following local custom in Erbil, tenant-farming agreements involved a 50/50 division of profits between landlord and tenant. The landlord had to provide a house, irrigation, and

tractor equipment. All other seasonal costs (seed, pesticide, etc.) were split in half. Under Firestone's (1975: 175) typology of tenant farming structures, the arrangement would have qualified as a "joint farming" form of tenancy in that capital investments were split between landlord and tenant.

Within this generic structure, an Arab tenant in Erbil would have to gauge answers to the following before entering into an agreement with a given landlord: Would the landlord pay his share of seasonal costs upfront at the beginning of the season (planting), or would he place the upfront burden and risk on the tenant, deferring his share of the costs to the end of the season (harvest) through deductions against the profit? Would the landlord leave the tenant to "his work" (*shughla*) without disturbance, or would he give "orders" (*owamir*) and require extra favors and tasks outside of those labors for which he was receiving a 50/50 cut?

Abu Samir determined that Kak Hashyar, whom he called "the Kurd" (*Al-Kurdi*), conveyed favorable terms and would work "as brothers" (*ikhwan*) without excessive "orders" (*owamir*). 80 donums would stretch the limits of Abu Samir's family's labor capacity, but he reasoned that he could always hire day workers among the camp-dwelling "displaced" (*naziheen)* at Qoshtapa during the intensive harvest periods for 10,000 dinars per day, per worker. Despite successfully establishing a farming operation in Erbil, the resources that Abu Samir could raise from his 80 donums would never be sufficient to fund the full burden of treatments in Beirut, however. He would have to rely upon Abu Haamid as well as Uthman for both cash and labor. Let us examine these exchanges as they unfolded and explore their contested status (as gift or loan).

In Erbil the resource and money-bearing household heads (Abu Samir, Abu Haamid, and Uthman) engaged in constant payments and repayments with one another, accompanied by close accounting of the balance. Most purchases on behalf of another household were repaid within the day. These expenditures and repayments were a result of the inconvenience and the danger of traversing the farm-town-city nexus more than absolutely necessary. No one wanted to waste gasoline, and no one wanted to interact with impromptu Kurdish *asayish* (Kurdish internal security) checkpoints for the sake of a small purchase. If, for instance, one of the household heads (or a deputy) happened to be visiting Doctor Street (*shara atuba*) in the city center of Erbil, another household head might request a pharmaceutical purchase. The requesting party would either send ahead cash for the purchase or provide repayment upon delivery of the item. Or, more commonly, one of the household heads might make a trip to the town of Qoshtapa to purchase rice and flour. They would inform one another by telephone, and they might make requests to be repaid upon his return. These exchanges were limited to single, discrete items – a bag of rice, a packet of butter, a vile of medicine, or a canister of seed. Large grocery or supply runs would fall on the shoulders of the household head himself, or one of his sons. The lead males from different households would fill the gaps for one another, but they would not make major and labor-intensive purchases on each other's behalf. They settled accounts quickly and exactingly in a kind of "balanced reciprocity," – i.e., equivalency in the value and delay of return (Sahlins 1972).

Long-term loans between the households were uncommon but not unheard of. Because Uthman's landlord was especially exacting and required his 50/50 profit cut at the end of each day (as opposed to weekly or even seasonally), their household often

struggle to amass the larger sums needed to purchase a season's worth of seed, fertilizer, and nylon. Occasionally Uthman would request cash from Abu Haamid or Abu Samir ($100 to $500). He would make the repayment ideally within a few weeks, but at the very most the end of the season. During the intervening delay, the household heads did not use the language of "debts" (*diyoon*) in relation to one another. They relied on the language of "requesting" (*talab*). Uthman might say, "One thousand dollars is requested/asked of me by Abu Haamid" (*matloob minne*), meaning, he needed to pay back Abu Haamid $1,000 at some point. Again highly deliberate accounting ensured that these payments and repayments were exact.

Illness-related exchanges obscured the limits around the quantity and timing of payments. While the initial pre-displacement offers of cash to Abu Samir were understood as gifts, the status of ongoing payments post-displacement were increasingly the subject of more vigorous contestation, debate, and tension. The chronicity of the illness and ongoing continuation of treatment required additional payments – on average $1200 from each household for each of Abu Samir's trips to Beirut for chemotherapy. Haitham, aligning himself with the stance of his absent father, sought to frame these ongoing payments as ambiguous and gift-like (no clear repayment), while Uthman and Abu Haamid tended towards increasingly loan-like language. Let us first examine illness payments to Abu Samir made by Uthman's household, followed by Abu Haamid's. Here we will see more clearly how the intimacies and rivalries within the kinship network shape the unfolding of transactions.

<u>Scene: Contesting a Gift</u>

One day towards the end of the farming season, I witnessed the act of giving funds to Abu Samir. Hours prior to the transfer, Uthman and Haitham emerged from the back rooms of their farm house holding stacks of 5,000 dinar and 25,000 dinar bills in their arms. They laid out the stacks on the floor and started the work of counting them out. They were stacking the 5,000 dinar bills into 100 bill stacks, so 500,000 in each ($450 dollars). When the counting was completed they arrived at 13,500,000 dinars ($12,000 USD internationally but $10,700 USD in the Erbil exchange). This amount represented the profit at the end of the summer in addition to the sale of some farming equipment. Now it was time to exchange the dinars for US dollars. Conducting transfers from dinars to dollars was a commonplace practice at the end of farming seasons, as it effectively placed cash out of everyday circulation and promoted savings. Uthman and Haitham placed their stacks of cash into a plastic bag and left the house for Erbil city. We went to the "bursar", an open-air market with small booths where men would count cash and distribute bills from other currencies. Following the receipt of US dollars, we walked over to a transfer center and sent $1,100 USD to their father Abu Umar. Finally, it was time to head to Abu Samir's house.

We entered the structure and sat down in Abu Samir's majlis. Uthman wanted to wait in the car, but Haitham urged him to come in. Uthman reluctantly complied. Abu Samir laid out on a pad lining the wall. His medical reports were stacked to his side: He was preparing for a trip to Beirut the next day. The four of us chatted about the problems with the watermelon market. Abu Samir fumed, "120/kilo, people are saying my product is sick. But it's first rate (*daraja ula*). 120/kilo! It'd be better to let it rot. Mac did you see my watermelon? Do you think it is sick too?" I said I didn't know. During a pause

Haitham inched closer to Abu Samir, who was resting his head on the palm of his hand. Haitham pulled out a stack of cash from the plastic bag at his feet. He tossed $7,500 USD onto the mattress next to Abu Samir without saying anything. Abu Samir took the stack and tossed it halfway back. Haitham returned it once again. “You’re sick (*mareedh*), you need this.” Abu Samir took the stack into his pocket and responded hurriedly, “I thank you, I thank you.” Uthman remained silent and readjusted his robe. They changed the subject immediately back to the price of the watermelons. The awkwardness of the nephew-uncle exchange was palpable, mostly because one of the giving parties (Uthman) remained entirely unengaged in the ritual.

Despite the fact that Haitham and Uthman passed by Abu Samir's home multiple times daily (on trips to and from the market) and could have easily given over the cash through the window of the car (as they did for most mundane repayments), at Haitham’s urging the $7,500 transaction had unfolded in a manner that followed the norms of a ritualized sickness visit. In Salahadin, Abu Samir received hordes of guests following his initial cancer diagnosis and trip to Beirut. He received gifts of cash and well wishes, including the initial $5,300 and $3,200 sums from his brothers. As his illness wore on for months and now years, he no longer received visitors on the basis of his sickness, with the exception of days or weeks in which he experienced acute and observable physical decline. The fact that Haitham maintained the ritual visit form associated with the onset of serious illness with each successive cash transfer disclosed the nature of the transaction: It was not a mundane exchange in need of quick repayment. These ongoing payments would retain the same vagueness as the initial gift of $5300.

When we left the house and boarded Uthman and Haitham's truck, a mood of reflective silence prevailed in the car. I tried to break through the rare lack of chatter and asked whether or not Abu Samir would eventually return the $7,000. Uthman quickly shot back, "Possibly, he should (*mafroodh*), he should (*mafroodh*), we are all displaced (*naziheen*)." Haitham let Uthman's words hang in the air for a minute or two, but then softly rebutted: "Abu Samir, he's sick (*mareedh*), and it's true that it's expensive, but money isn't everything (*mo kul shi floos*)." The phrase *mo kul shi floos* (money isn't everything) is one of a series of common indications that rigid accounting should be left out of close relationships. Haitham's frequent insertion of this phrase and his reminders of Abu Samir's condition as "sick" (*mareedh*) affirmed the legitimacy of the uncle's continued receipt of unconditioned funds. But Haitham did not cross his brother harshly, and nor did he make any definitive judgment as to whether the transfer would require repayment. The questions of accounting and repayment would be deferred to a later date.

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The possibility of this deferral was, in part, enabled by the suspended ethics and uncertain temporalities of the "displaced" (*naziheen*). Normal dynamics of repayment and obligation could be violated without losing face. Haitham used the discourse of displacement when justifying the continuation of treatment support: "Abu Samir is sick, and he's displaced, and he's alone [without any grown sons], so we all make a 'collective sum' (*jama'iyah*) and do what we can." For Haitham, living as *naziheen* along the "ditch" (*hufr*) removed the need for concerning oneself with long-term investments. "At any moment the Kurd can come and say, go, get out! So here in Erbil we can't rent or buy land. What's the benefit? We are *naziheen.*" Money was not "important" because savings

were meaningless in an environment of potentially imminent expulsion. Such ambiguities granted Haitham flexibility in justifying large transfers to Abu Samir given the absurdity of long-term investment. Uthman would agree with Haitham about the futility of long-term projects of inhabitation, but for Uthman potential expulsion raised the need for savings. He would press Haitham, "At any moment, the Kurd can say, 'go', and then you have no money in your pocket, what do you do?" Uthman also emphasized the immediate deficits and scarcity of displacement – the cutting down on baby milk for the kids, the inability of the children to attend school due to the cost of transport, and the immense burdens of small unexpected illnesses, etc. "Displacement" (*nzooh*) could be utilized to justify nearly opposite logics of support and withholding.

Uthman would often mention the draining impact of Abu Samir's treatment as a final damning factor in a long litany of financial hardships. During a trip to the market he noted:

> "Now I can't even save 300,000 (IDs) [$250 USD] after a season. I mean we'll eat only bread or soup for 3 or 4 days sometimes. The farm, concerning the farm's expenses, I go shopping from the [agricultural] store and use a loan, I put, you submit an amount, and then when the harvest time comes, it turns out you are wanted for debts. You get no benefit from it. Now, if you work as a laborer your daily pay is 5000 ID's, by God it would be better. I mean, I loaded a car of watermelon and sent it to Erbil, and it sold it for 60,000 IDs. And then 2 tires of the car exploded. I went and bought them (tires) for 135,000 (ID). Meaning the loss from my pocket was approximately 75,000 (ID) on the day. And if you divided by the children, by the workers who worked, 10 persons divided by 60, I

mean, each person would turn out about 6,000 (ID). By God, it's a loss (*khisarah*). *We'd, well we'd be okay if it wasn't for Abu Samir. 10 papers ($1000), then 20 papers ($2000) each time he goes to Beirut, by God it's a lot.*"

With very little profit margin at the end of a season (due to splitting profits with the landlord and then paying Abu Samir), the startup costs for the new season would have to be acquired via credit with the local seed store. And then the whole orientation of the new season became one of paying off those debts. The cycle repeated itself over and over, with little chance of cash accrual, especially given the constant potential for accidents and surprise losses. "There's no benefit" (*mako istifadah*), a common phrase among the agricultural Arab *naziheen* in Erbil, was always ready on Uthman's lips. Crucially, Uthman concluded the litany of complaints by indicating the possibility that their efforts might have been profitable *if only* for Abu Samir.

Counting

Abu Samir's younger brother Abu Haamid contributed to the illness "collective fund" (*jama'iyah*), and substantively the sums he gave over were on par than those of the other household. However, he was perceived as increasingly cutting corners as the chronicity of the illness brought the kinship network into the second, third, and fourth years of transferring funds. The force of Abu Samir's complaints about his younger brother had to do with the style of the transfer and the implications embedded within that style. By phone or word of mouth Abu Haamid always made note of the numerical amount of the sum when transferring cash to Abu Samir. The designation of the amount removed the ambiguity around the transfer: It clearly bore the marks of a loan and

implied debt – irrespective of whether or not the amount would actually be repaid. Moreover, Abu Haamid sent the cash to Abu Samir's house via one of his sons, removing the ritualized aspect of the exchange. Abu Samir expressed open disgust about the situation, speaking almost as if no money had been given at all: "By God my brother, Abu Haamid, what a problem Abu Haamid! By God my brother is a problem (*moshkala*). He has a lot of money and just spends it on his house. I have less money and I have to spend it all on treatment! He was like this in Salahadin, and he's like this here." Abu Samir went so far as to reinterpret Abu Haamid's initial gift of $3200 as a loan.

When I farmed on Abu Haamid's plot and accompanied him on walks through his crops and fields, he never overtly expressed resentment towards Abu Samir for placing this economic burden on his household. He spoke in a measured cadence and never raised his voice. He exuded calm and detachment. Nonetheless, the rivalry with his brother subtly surfaced in any discussion of finances and household budgets. Once I was driving with Abu Haamid to the market. He recounted the losses incurred during displacement from Salahadin:

> "I lost a lot. I mean if I total the number, and I'm younger than Abu Samir, I tell you it'd be, well it'd be almost 500,000,000 dinars. By God the almighty. Approximately 50 notebooks (500,000 USD). By God the almighty. The tractor was 5 notebooks ($50,000 USD). The [unintelligible] was 4 and a half notebooks ($45,000 USD), and the [unintelligible] the was 2 and a half notebooks ($25,000 USD). The KIA truck was about 2 notebooks ($20,000 USD), the cows were 2 notebooks ($20,000 USD), the field I bought, I bought it for 15 notebooks ($150,000 USD), and my house was 3 notebooks ($30,000 USD). Just ask Abu

> Samir how much I lost. He lost too, but less. Less, less, about 10 notebooks ($100,000 USD)."

At first glance, there is nothing particularly striking about this account. All of the siblings and nephews were constantly counting the prices at market, the cost of equipment, the cost of seed, the speculative cost of a non-agricultural business venture, current losses and gains, past gains and losses, etc. This was the basis of the daily genre of bullshitting called *hachi zira'i* (farming talk). Abu Haamid added a dimension of weight and competitiveness to *hachi zira'i,* however. He repeatedly drew attention to his costs/possessions versus those of his brothers, always hinting at the slight edge he had gained despite his young age. Simultaneously the extent of his losses in displacement lent justification to his reluctant posture towards contributing funds to the "collective."

In response to Abu Haamid's frequent assertions of major displacement-related losses, Abu Samir insinuated that Abu Haamid suffered from a broader obsession with counting and accounting, while ignoring other important duties:

> "He says he has no money! By God Abu Haamid, these days he's always praying now, sometimes he says, 'I prayed five times.' Or, 'I fasted all the days of Ramadan.' Son of a dog! I haven't prayed for years. How can we? We are farmers, tied to our work. But then you see the roads around his plot and they are filled with mud, you can't traverse them! And this is the path of Muslims, the road of Islam (*tareeq al islam*). We all use this road."

Indeed, Abu Samir would grow livid every time he was forced to turn around his truck at the sight of one of Abu Haamid's puddles. The point here is to note that agricultural and

Islamic notions of counting and accounting[59] – both of possessions and prayers – take on a contested meaning in the tussle between the two brothers over the distribution of resources and illness-related support. As we will see in the upcoming sections, the rapid dawning of the dying space heightened this struggle.

Preparing for Death (2016 –)

It was the mid-summer of 2016, around the time of the water melon harvest. When I heard from Haitham that Abu Samir was "very sick" and "between life and death" (*beyn al hayah wil mout*) following a trip to Beirut, I hastened plans to visit. His wives had laid out a straw mat on the grass. We sat in the shade of his house overlooking a 10-donum patch of watermelons. To our right his wife Mariam and sons were huddled around a stack of planters, carefully placing seeds in pods. Normally they would perform this activity further out in the fields, but they shifted the spatial organization of labor to accommodate Abu Samir's need for shade. His eldest son approached, extended greetings to me, and proceeded to massage Abu Samir's thighs and legs vigorously. Later one of his youngest sons came over and tried to mimic the action. "It helps my legs during the chemotherapy," noted Abu Samir. Abu Samir hated "the pills," as he called them. He was orally taking Xeloda, a chemotherapy agent in between doses of cisplatin in Beirut. The familial recognition of the dying process is manifested in the reshaping of household arrangements. As Lawrence Cohen (1998) notes in his book *Aging in India*, a family might place a dying person's bed on the threshold of the house to indicate both the

[59] Here I am thinking of Naveeda Khan's (2010: 115 - 118) discussion of the place of numbers and counting in the Islamic tradition.

person's liminality (neither part of the domestic nor removed from it) and her honored status in being the first person to greet/welcome guests (Cohen 1998: 182). In Abu Samir's case, perhaps one could say that he was not placed on the threshold of his home but on the threshold of his fields.

In the upcoming section, we see how Abu Samir's repeated trips to Beirut render his dying episodic and therefore a matter of contestation across the kinship network, eventually compelling him towards the forging of closer ties with neighbors across lines of sectarian difference. In Desjarlais' (2016) *Subject to Death*, he emphasizes the "intersubjective" quality of death. Death always prompts a gathering of visitors: "Once people know that someone is going to die, then people go just to comfort the family" (2016: 54). "Everyone knew" that the man was going to die, Desjarlais notes during one such episode of decline. This section explores what happens when chronicity renders the anticipation of death a certainty for some and a question for others across a kinship network.

While social science studies in Arabic-language Iraqi journals have explored lay understandings of death through surveys conducted in Baghdad (Taieb & Ali 2009, Mohammad 2014), less attention has been paid to the specificity of negotiations of death and dying under conditions of war in Iraq. Anthropological literature on death and dying has explored how experiences of dying are shaped by cultural practices and rituals (Desjarlais 2003; Block and Perry 1982; Hertz 1960), as well as how biomedical techniques make possible the extension of life and the management or timing of death (Locke 2002). Studies have also examined death and dying in relation to the biopolitical precariousness of many populations facing poverty and violence (Scheper-Hughes 2004).

Although I situate Abu Samir's journey in relation to the precariousness of healthcare under the deterioration of the Iraqi oncology system, my focus is not on general behavioral patterns around death and dying that emerge in response to precariousness within a given context, such as how outward expressions of grief may not be present in a place of pervasive child death (Scheper-Hughes 1993). Building upon Das (2012), Kwon (2008), and Al Mohammad (2014), I will ask how behaviors and labors around death in a specific kinship world can be approached in terms of their singularity, with the understanding that comportments may vary widely across different members of the kinship network.

This period in the illness trajectory will also highlight the role of old and new neighbors — those in Salahadin and in Erbil. How might preparations for death generate heightened efforts to facilitate relations beyond the kinship network? This discussion will require engagement with questions of sectarianism in Iraq. There has been much ink spilt on the problem of political and demographic shifts in Iraq in the post-2003 era and how these shifts have effectively separated 'Shia Arabs,' 'Sunni Arabs,' and 'Kurds' into increasingly distinct communities. Scholarly discussions of sectarianism in Iraq emphasize a narrative of pre-war conviviality turning into post-war factionalism along sectarian or ethnic lines (*See* Ismael & Fuller 2009). The before/after narrative of sectarianism has become ubiquitous across disciplines to the point that scholars with no experience or expertise on Iraq stand ready to repeat it. Renowned anthropologist Marshall Sahlins argues that the tactics and discourses of the US-led Occupation depicted sectarian conflict as "natural" and thereby ignored a *previous* history of Sunni-Shia intermarriage, and a *previous* history of Sunni-Shia conscription in the army (Sahlins

2011). There is no attempt in Sahlins' essay to inquire about what *current* inter-sectarian relations might consist, except to suggest that they are now politically and socially severed. Across the disciplines there is insufficient attention to new inter-communal encounters and relations,[60] particularly at the level of local neighborly and kinship ties. If Sunni Arab, Shia Arab, and Kurdish individuals and families still navigate lives in shared everyday social and community spaces, the scholarly record is virtually silent on this.[61] One aim of this section will be to tie Abu Samir's struggle with dying to overlapping networks of kin and neighbors across lines of ethno-sectarian difference.

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Before describing my June 2016 visit to Abu Samir's house in further detail, some context is required. Prior to the visit by a few weeks, Abu Samir started to feel a troubling "numbness" (*tanamol*) in his nose. He abruptly decided to buy a ticket to Beirut for examinations. He travelled alone in order to save money. Funds were becoming scarce. In Beirut, the oncologist put him through a series of examinations and tests. He was informed of possible metastasis to the lungs, and the surgery would cost upwards of three notebooks ($30,000). Haitham, in turn, asked me to call the Beirut oncologist to stress the difficulty of their financial situation as "displaced" (*naziheen)*. Haitham said: "Tell her, tell the doctor we're *naziheen*, and we don't have the money [pause]. Mac by God we don't have it" (*wallah ma 'edna*). Haitham's capacity to gather a "collective" (*jama'iya*) had reached its limit. As tenant farmers it was possible to gather piecemeal sums over

[60] Visser (2007a; 2007b) has issued a helpful critique of notion that political sentiments are now predominately organized around ethno-sectarian divides.

[61] See Khan (2006) for a discussion of how everyday life is a necessary frame for understanding sectarianism.

time for regular chemotherapy payments, but they did not possess sellable assets enabling the amassing of larger lump amounts. Ultimately, they decided to forgo the surgery and continue with chemotherapy, the first major break from the standard of care recommended by Beirut oncologists.

The Visit

Now, sitting on his mat and overlooking the fields, Abu Samir complained of "numbness" in his nasal cavity as well as the inability to walk. "When I walk I fall down. By God I'm not working at all." The inability to walk and the incapacity to work were intertwined: The supervisory duties of a household head involved, first and foremost, a great deal of "walking around" (*yaftor*). Normally, as Abu Samir walked from field to field, he checked the irrigation pipes (*bowari*) and the valves (*kakat*) leading into the water hoses running across the fields. This work of oversight-through-movement was constitutive of the head of household's authority.

It also signaled his control over external relations: To "walk around" also meant traversing the road separating his plot and that of Kak Hashyar, his Kurdish landlord. Abu Samir would approach Kak Hashyar and engage in "farming talk" (*hache zira'i*), which again is a genre of male talk characterized by mutual exchange of commentary on watering levels, pesticide usage, gains and losses, and so on. "Let's go chat with Kak Hashyar," was an utterance I heard fall from Abu Samir's chapped lips numerous times during the hot summer days of watermelon season, as well as the frigid winter harvest of cauliflower. They chatted about the slight differences in farming techniques in the Kurdish north versus central Iraq. "Farming talk" is an activity between two peers, and

Kak Hashyar engaged in these passing encounters without overly asserting his contractual leverage over Abu Samir. Any "orders" (*owamir*) to Abu Samir would be given at another time. But at this moment, he found his body unresponsive to his attempts to move across his plots or across the road. The placement of his mat next to the fields and under the shade of his house was, in part, an act of concealment: He did not want Kak Hashyar to see him in an unproductive state and thereby cast doubt on his capacity to sustain long-term tenancy relations.

Abu Samir's incapacitation shifted the dynamics of labor and supervision on the farm, if only for brief moments. From his mat he could shout a directive or two, but fatigue quickly set in. During the seconds, minutes, and hours when Abu Samir's strength would no longer allow him to sit up, he would coax his body downward and sleep on the mat. Today, his head rested just a few inches from my seat. Then, before my eyes I witnessed a fleeting transformation. His eldest son Samir, fully aware of his father's slumber, took over supervisory duties, shouting commands and scolding the children. I remembered in this moment Abu Samir's fondness for saying, "Death? I am not worried, we die everyday when we sleep." This Islamic notion of sleep-as-death allowed Abu Samir space to minimize the finality of the end to come (*See* Smith and Haddad 2002). But for those who remained awake while Abu Samir slumbered, the micro-deaths provided a brief window into what was to come on this side of the grave: Samir would become the head of household in the event of Abu Samir's demise. The vision would pass quickly. When Abu Samir woke again, Samir would fade into the larger group of women and children once again.

A Second Visit: 'Turning' the Kurds

It seemed that Abu Samir's relation to the illness was changing. Before this most recent trip to Beirut and round of chemotherapy, Abu Samir typically deflected any direct talk about the possibility of death with a kind of dark humor: "Death? It's nothing. TEEET! You fart and then you die!" But nowadays Abu Samir reflected on death with a more measured and anticipatory posture, expressing a high level of concern around the implications of leaving a headless household behind amidst fraught external and internal relations. He was brought into a relation to dying through awareness of a faltering body unable to "walk around," and the acceptance of a sub-optimal treatment protocol (chemotherapy instead of surgery) resulting from limited financial resources. Abu Samir was not subject to death in some unambiguous sense; however, the gradual acknowledgement of dying raised acute anxieties, particularly the question of whether his son Samir could step into the role of household head after his demise.

I visited Abu Samir the night before his trip to Beirut for a second dose of chemotherapy. He was brooding and avoiding small talk. His young wife implored, "what's with you" (*aysh bik*). He gave her an understanding look, perhaps conveying that they would speak later. After dinner, when everyone had cleared out, I tried the same phrase, laying down on the mattress next to Abu Samir. "Are you mad about something Abu Samir? Did I say something?" He said, in a lowered voice:

"No Mr. Mac, I'm worried, God don't let it happen (*la sameh allah*), if something happens to me, then...The Kurds could say, get out of here, go. My son is young, and he

doesn't have the skill to turn (*sayyis*) them. And Mariam, she is worried about what will happen to her."

"God don't let it happen" (*la sameh allah*) is typically a phrase people use when discussing the implications of potential deaths of third person others (e.g. God don't let it happen, if your mother dies, then…), or any number of unfortunate events (e.g., God don't let it happen, but if we lose in the fight against *daesh*, then…) Here Abu Samir turned the phrase on himself and examined the byproducts of his death as if from an external position. Above all else, the prospect of his death highlighted the delicate nature of landlord relations. Abu Samir knew how to *sayyis* the Kurds, he noted. He was unsure if Samir would be able to do the same. He was only 17. He was unmarried. *Sayyis* in this context means something like "manipulate" or "influence" or "turn." Abu Samir rotated his hand as he uttered the word to signify the skill of turning Kak Hashyar towards a desirable direction. *Sayyis* shares a common root with *siyasa* (politics), a link that underscores the connection between faculties of "turning" others to the faculties of state and family governance. If Abu Samir died, the family would be left without a household head capable of managing relations with the Kurds.

Other threats existed within the realm of kinship. Abu Samir noted the concerns of his wife Mariam. She feared being sent (with her three young boys) to Abu Haamid, who was married to her elder sister. Abu Haamid was well known to give slaps (*rajdiyat*) as well as more significant beatings to his young wife in the plain sight of others, a prospect that Mariam now feared for herself.

Over several weeks following the commencement of chemotherapy, I noticed that whenever Abu Samir slumbered on his mat at the threshold of the tomato field, Samir

continued to step into carrying out the basic functions of supervision. He worked vigorously and never commanded others without also providing assistance to his sisters and brothers. Even still, if there were to be any hope of Abu Samir's line remaining independent following his death, Samir would have to become a more credible head of household figure. In short, he would have to be married. Abu Samir's preparations for death soon became intertwined with securing a marriage for his son. Achieving this end would require the cooperation of the other household heads, who would be reluctant to marry off one of their daughters to the young and inexperienced Samir hastily. Would the other households recognize and respond to Abu Samir as having passed over a certain threshold of illness, with his push for marriage stemming from a legitimate concern over dying?

Negotiating Marriage

One problem with the timing of Abu Samir's push for marriage was that his body soon regained strength with the end of the chemotherapy cycle and the start of the winter season. His family put his mat by the fields away, and he returned to walking up and down the crop lines. Still Abu Samir continued to see himself as a man whose demise was imminent, and he saw Samir's marriage as an immediate imperative. This acknowledgement of dying did not necessarily register across the kinship network. Some, particularly Uthman, would go so far as to contest his status as "sick" (*mareedh*).

Abu Samir intended to take "two women" from Uthman's household, one for Samir and one for his slightly younger (16 yrs.) son Haitham. The conflict that ensued revolved around price: Abu Samir insisted upon a $1000 price for each woman due to the

exceptional circumstances brought on by illness and displacement. During one negotiation in December 2016, he repeatedly noted that he was “sick” (*nazih*) and they were all “displaced” (*naziheen*). He even uttered explicit pleas of assistance such as “help me a bit” (*sa’idni shway*). Uthman deflected the discourse of exceptionality by resorting to the language of female honor, challenging Abu Samir with statements such as: “$1000. What are you saying? My sisters are cheap?” The typical arrangement in Salahadin would have been approximately $3000, which was the amount Abu Umar (Uthman’s father) had paid Abu Samir to marry Haitham to one of his daughters several years earlier. Abu Samir’s push to accomplish the marriage quickly and cheaply grated on his resource-strapped nephews in Uthman’s household, who saw their duty as representatives of their father to ‘protect’ their female kin. Even Haitham, the longtime *murafiq*, was reluctant to come to Abu Samir’s defense. The strong masculine norms around marriage gave Uthman a new and powerful symbolic arsenal. Categories of protecting female honor shut down Abu Samir’s entreaties for leniency and recognition of his special vulnerability.

Again, another factor damning Abu Samir's position was the gradual wearing off of chemotherapy's physical effects. As negotiations languished, physically Abu Samir improved. He no longer spent his days on the mat. He could even lift bags of flour and rice onto his truck. When Abu Samir would deny an invitation for a shared meal with the other households on the basis of sickness, the household heads and grown males would quip: "He's not sick. He's carrying those 25 kilo bags of rice!"

The timing of the negotiations was also unfortunate from the standpoint of cross-household economics. Uthman’s household was currently in the process of transferring

its belongings and agricultural production from one plot to another. Relations with their first Kurdish landlord had recently soured. Over the course of the summer, the landlord had ratcheted up increasingly excessive demands (*owamir*), ultimately leading to a soft eviction. He told them that he wanted to plant wheat during the next season and thus he would not require their services. They would have until January 2017 to locate a new plot and move. The pressure to move quickly came less from the January deadline and more from the timing of the seasons: If they did not find a plot quickly and plant seedlings for the spring/summer harvest, they would lose out on the earnings of a whole season. They finally located a potential landlord, but their situation remained difficult.

With Uthman's household under heightened financial distress, Abu Samir's attempts to claim sympathy through the idioms of displacement and sickness lost considerable persuasive power. Even Abu Samir's longtime companion and ally Haitham eventually aligned himself with Uthman's position, though he avoided directly confronting and offending Abu Samir. The negotiations stalled for months, and for a period neither Uthman nor Haitham paid regular visits to Abu Samir. They passed by one another on the roadways and exchanged very brief greetings. Haitham would intentionally drive by Abu Samir's plot in order to facilitate small encounters and exchanges of words, but he would not enter into lengthy visits. During this period Haitham also ceased traveling to Beirut with his uncle.

A Home Destroyed

An unexpected event brought the households back into an acknowledgement of Abu Samir's vulnerability. Abu Haamid called me on the phone and beckoned me to visit

him. I knocked on his door. He prefaced the conversation by saying that he did not want me to mention the content of the conversation to Abu Samir. “Don’t say anything. He knows, but still don’t say anything. It will sap his immunities.” This phrase, which I had heard many times in hospitals, was the utterance often used by family members to caution against informing a patient of a worsening prognosis or, in some cases, the presence of the disease in the first place. I prepared myself for him to tell me about a bad report indicating backward progress. He stood and uttered: “Abu Samir’s house, Abu Samir’s house in Salahadin they destroyed it…but don’t mention it.” It struck me that Abu Haamid, who usually maintained out an antagonistic relation with his brother Abu Samir, was treading with such care.

In line with many studies of disclosure practices and cancer (1999), Iraqis acknowledge the potentially powerful reactions to the utterance of the diagnosis of the disease and its advancement; however, the concealments around the disease are situated amidst a wider field of suffering in which the mismanagement of the ruptures and loss of war may threaten the health of the person more severely than negative prognostic information. One must attend to this wider field of concealment and disclosure. Abu Haamid wanted me to tread carefully.

The event rippled across the three households, reaffirming Abu Samir’s status as a sick and vulnerable man. Abu Haamid proclaimed repeatedly: “They destroyed Abu Samir’s home. In Salahadin. yesterday…And you know what? They knew he was sick!” He went on to reiterate again that I should take care with my words around Abu Samir and to avoid bringing up the subject. He’s in “agony” (*qahr*), Abu Haamid noted. Over

the next few days Uthman likewise made visits to Abu Samir and expressed his sympathies about the house.

The destruction of Abu Samir's home consolidated the increasingly inevitable conclusion that return to Salahadin in the near future was out of the question. The other household heads now had to contemplate the implications of Abu Samir's death in Erbil. Abu Haamid reflected:

> "There's just Samir in his house. He helps a lot. But that's it. The rest are women and children and they can't do everything in a farm. Now I'm doing ok, I have some elderly sons. But if Abu Samir dies and his family is young in age, it'll be a burden (*aleya zahme*). If we were in our homes in Salahadin, no problem, but we are displaced, and tomorrow maybe the Kurds will say to Samir, get out. You have to expect everything. If he dies, it'll be a burden on me."

As residents of Erbil, Abu Samir's death would almost certainly mean the merging of households. With Samir only18 years of age, it was highly unlikely that a Kurdish landlord would treat him as a head of household, Abu Haamid contemplated.

Abu Haamid quickly became a proponent of Samir's speedy marriage, as a union would at least hold out the possibility of establishing a new household head. Uthman continued to show resistance, however. During negotiations Abu Samir liberally unleashed curses upon God and his nephews, which in turn provided Uthman fodder in calling into doubt Abu Samir's moral legitimacy as a dying man. Uthman would allege that Abu Samir had no business "cursing God" (*ykfor*) and defiling religion. Uthman's insults drew their force from a certain image of ethical progression for a seriously sick person. He charged Abu Samir of acting "crazy" (*khibil*) and immorally in a way that

defied the precepts of Islam as they pertained to the ill and dying. The "afterlife" (*al akhira*) creates an ethical imperative in the present towards prayer and the works of goodness (Smith and Haddad 2002).

Wedding

Abu Umar, the absent household head residing in Ankara, grew impatient with Uthman's stubbornness on the bridal price. He and his cohort had long been consumed with transitioning to life in Turkey, but now he started asserting himself upon the household in Erbil more directly through phone calls. (Against the objections of his sons, he wanted to remain in Turkey in order to preserve a secondary haven for them in the event of expulsion from Erbil.) He sent an emissary in the form of his first wife, Um Umar. She would not leave Erbil until a marriage deal had been made. Upon arrival in late December of 2016, Um Umar quickly inserted herself into the negotiations. She was careful not to squash her son Uthman, but she served as a bridge between the estranged households and kept open lines of communication over the phone with Abu Umar. Abu Haamid likewise lent support to the process, constantly affirming Samir's readiness for marriage despite his young age. The guarding presence of the elder mother partially diffused Uthman's claim that a lowered bridal price would dishonor his sister. A deal was reached within a month's time. The wedding between Samir and one of Uthman's sisters transpired soon after.

The wedding became an occasion for collective lamenting about the effects of displacement on resources. Expressions such as "this [wedding] is nothing," (*mo shi*), "the situation is tired" (*wadha ta'ban*) circulated among the households and even among

the guests. Everyone excused the lack of multiple sheep and other common touches on the grounds that they were all "displaced" (*naziheen*). Kak Hashyar and the other landlords of the area were present as well. One of them loudly complained of not having any sheep on his dish. At the end of the event, Haitham reflected: "In Salahadin, normally we'd put out a lot of chairs…We'd have an artist come, and he'd sing songs about Saddam…We'd get several sheep." To this day it remains unclear to me whether or not this displaced wedding rendered Samir closer or further from being the household head Abu Samir hoped to construct.

'Turning' the Kurds Once More

As Abu Samir's health worsened yet again in the spring of 2017, he began to pray for the first time in decades in preparation for his demise. He redoubled efforts to solidify a place within the world of the Kurds while simultaneously leaving the possibility of the resumption of relations with his former Shia Arab neighbors in Salahadin. He received vociferous criticism from Abu Haamid, Uthman, and even his longtime companion Haitham for what they perceived to be an increasingly obsequious posture towards Kak Hashyar, his Kurdish landlord. Once Abu Haamid confronted Abu Samir, saying: "Any time he gives you commands (*owamir),* you immediately say "done, done" (*sar, sar*), but that's *not* your work!!!" Abu Samir would counter these comments by praising his Kurdish neighbor in the company of his relatives — at the expense of his brother Abu Haamid:

> "By God my brother Abu Haamid doesn't ask me if I need anything for my treatments, but Kak Hashyar, a Kurd, comes and asks, do you need anything?

Money? By God he even gets nervous to ask me for his share [of the profits]! And my brother says, you're 3000 in debt to me! And I'm sick!"

The performance of complaints over his brother's failures through the language of cross-sectarian affinity should not be taken as a sign that all praises of the *Kurdi* were cynical attempts to prod his kinsmen. In general Abu Samir presided over a discursive field that framed the Kurds as reliable business partners and hospitable hosts. He lauded Kak Hashyar as a "great person" (*khosh insan*) and as one who had fulfilled the duties of hospitality: "By God Kak Hashyar hasn't held back from us" (*wallah Kak Hashyar mo qasran wiyana*). Abu Samir's male children followed suit and used similar language to describe their Kurdish overlords.

Abu Samir was simultaneously laying discursive groundwork to preserve the possibility of a return home alongside his Shia neighbors, resisting participation in the moral arguments for violence or retribution on all sides (*See* Spencer 2000). Whereas the other two households often recounted the events of displacement in explicitly sectarian terms and directed partial blame towards the neighbors, Abu Samir shaped the events in generic, political language. For Abu Samir, leaving open the possibility of return to Salahadin meant excising the neighbors from the accounts of displacement, even though several kinsmen insisted that Abu Samir's next-door neighbor participated in a meal at his house the very day before helping militias overtake it. His brother Abu Haamid once asked rhetorically: "Why did our neighbors, and the militias, destroy our property? And burn Abu Samir's house to the ground? I'll tell you the reason, the reason is that we are Sunna. They tell you, you're my enemy (*adu'i*). And the government is behind me, and I'm destroying your house…How can you go back and your neighbor expelled you?"

Here the role, agency, and malice of the neighbors is foregrounded in explicitly sectarian terms, alongside the impossibility of return. Abu Samir, in contrast, would say to assembled groups of relatives and/or Kurds: "By God we were in our houses in Salahadin immediately next to the Tigris. There is no *daesh* anywhere. And the militia *hashd shaabi* (PMF) comes and says, you are *daesh*, get out!!!" Abu Samir has persisted in framing culpability as exclusively a matter of the militias, and only with great hesitation and hushed tones will acknowledge any role of the neighbors.

Conclusion

The chapter has explored three periods in Abu Samir's journey, which coincide with different justifications for granting or withholding illness support. These justifications were drawn from a context that repeatedly thrust new contingencies upon the kinship network. One could never predict how these contingencies would become drawn into the illness trajectory. The burning down of Abu Samir's home in Salahadin shaped the mobilization of illness resources in his favor after a lengthy period of declining kinship support. The ethnography has also shown how displacement shifts the sets of neighborly and commercial relations in which Abu Samir is embedded. As he struggles to secure consistent cross-household support amidst chronic illness and protracted displacement, his access to financial resources becomes largely reliant on the establishment and maintaining of neighborly and patron-client ties across lines of sectarian difference. The assertion to his Beirut oncologist, "We brought [money] from here and there (*njeeb min hinna wa hinna*), from relatives and neighbors (*min qaraib wa jiran*)," can now be seen as encompassing a world. Abu Samir is never in control or

possession of the illness' unfolding across a whole host of relations. The illness draws out a diverse set of voices – brothers, nephews, wives, sons, neighbors and doctors – sometimes helping, sometimes frustrating the trajectory that Abu Samir envisions.

The interventionist mode of US engagement with the country has generated numerous categorizations of time, space, social relations, and mobilities: Conflict and post-conflict; internally displaced persons, refugees, and returnees; sectarian and non-sectarian; and most recently, pre-ISIS and post-ISIS. I have suggested that elaborating a singularity – the life world of a single sick man – provides a view into how an illness journey cuts across and puts such categorizations into question, while also showing that they do continue to bear upon social worlds.

CHAPTER FOUR

The Companions: Temporalities of Illness Accompaniment

In the previous chapter we have already been introduced to Haitham, the nephew who typically served as Abu Samir's "companion" (*murafiq*). He and his uncle Abu Samir lived in adjacent houses and farmed adjacent plots for decades along the Tigris River. When Abu Samir first developed symptoms in 2013, it was Haitham who drove him to the clinic in Yathrib, Salahadin at his father's (Abu Samir's brother) suggestion. Haitham was already the person designated with most special transport duties across the three household kinship network, as he was responsible for buying complex machine parts, interacting with officials in Baghdad, and transporting sick or ailing members to clinics. Responding to Abu Samir's irritations resembled long established duties. The pharmacist of the rural area identified Abu Samir's swelling around the nasal cavity as merely temporary *jiyoob anfiya* (pockets of the nose, i.e., nasal congestion). The irritation and numbness continued. Haitham grew accustomed to receiving calls from Abu Samir with the same request: "Haitham! *Yallah* let's go to the doctor!" Haitham would put aside his work in the fields and board a KIA truck with his uncle. Blood flowing from the puffy cavity dowsed hand towels. The distance between the farm and the rural clinic in the nearby town of Yathrib was only a few kilometers, and Haitham traversed the terrain as quickly as he could.

Despite regular medications, symptoms continued. The pharmacist in Yathrib exhorted Haitham and Abu Samir: "Look, I will literally pay you to STOP coming to me. Please stop coming. I say it's *jiyoob anfiya*. This is what I know. If you want something

more, please go somewhere else." Haitham now found himself shuttling Abu Samir across the northern half of the country. They followed agricultural routes for selling produce, first attempting clinics in Baghdad, then Kirkuk, and then Erbil – the three cities where they most commonly sold their crops, in descending order. Each successive switch in treatment location placed Haitham in the position of leaving his agricultural labors for increasingly lengthy and arduous stints. Especially since the pullout of American troops, physical distances between major cities no longer reliably indicated speed of arrival. Checkpoints, both permanent and impromptu, dotted the roadways. Proliferating militias along major roads were prone to make arbitrary stops. The trip south to Baghdad could take one to four hours; the trip north to Kirkuk could last four to ten hours; the trip to the far northern province of Erbil could last seven to thirteen hours. As lower-class Sunni Arabs they were subject to suspicion and heightened security checks among certain units of an Iraqi Army they considered sectarian, in addition to the Kurdish *peshmerga* units guarding the periphery of Erbil. Haitham was regarded as the savviest of the second-generation males in interfacing with officials, policemen, and soldiers. "He knows how to manipulate (*sayyis*) them," Abu Samir noted. His selection as *murafiq* was justified along the lines of these aptitudes. He was Abu Samir's protector, negotiator, and companion. This chapter will examine the changing role of the *murafiq* through an ethnography of Haitham's multi-year journey alongside Abu Samir.

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During trips north to Kirkuk and Erbil, they would leave Salahadin in the early morning and try to make it back home by nightfall. It was a lengthy journey. Dangers associated with road travel were already intimately tied into Abu Samir's etiological

understanding of the gradually emerging illness. As symptoms worsened, Abu Samir started to make mention of lingering recollections that had not surfaced into speech for quite some time. Along the roadways, he recalled to Haitham the story of his brief cross-border passage into Kuwait during the Gulf War. His infantry unit received an order to engage in a "training exercise" in Kuwait. En route to their destination along the periphery of Kuwait city, the army truck tumbled off the road and threw all 30 soldiers into a ditch. The driver had been sleeping. Abu Samir barely emerged alive, with dozens of broken bones in his legs and a smashed face and nasal cavity. The physician in charge of Abu Samir's case in Kuwait evidently spoke of potential future problems. Abu Samir exclaimed, "By God the doctor told me then, this won't affect you now, but later it will!" Abu Samir started to associate the long-past road injury with the emergence of the still mysterious symptoms. Haitham was unsure as to whether the explanation was entirely plausible, but nonetheless he paid extra attention to the road in an effort to avoid upsetting his uncle. Sensitivities emerging from a history of war shaped modes of care in the present.

When after 13 months of trips northward an oncologist in Erbil finally informed Abu Samir and Haitham of the unfortunate presence of "tumors" (*owram*) and "cancer" (*saratan*), the specialist accompanied the diagnosis with a directive: The disease was at a beginning stage and chemotherapy in Erbil's public clinics would require a 3-month wait; however, treatment "abroad" (*bil kharij*) could commence immediately. Haitham briefly slipped into a secondary role. With the announcement of the disease category "cancer" and the decision to travel abroad to Beirut for treatments, Abu Samir's brothers were compelled to take on greater roles in expressions of fidelity to their brother. His elder

brother Abu Umar (Haitham's father) took it upon himself to raise the initial sum of money. He insisted upon accompanying Abu Samir to Beirut. He informed hundreds of individuals across the Yathrib region, and they in turn paid visits to Abu Samir prior to his departure. The overflow of fraternal assistance left an indelible impression on Abu Samir: "By God my brother helped me a lot," he said three years later.

But no one – not Abu Samir nor his brothers – had any concept for the chronicity of the disease and the duration of treatment. The initial eight thousand dollars they raised barely covered two weeks of examinations and accommodations in Beirut. Abu Samir's elder brother soon returned home to take responsibility over the farm, calling Haitham to come to Beirut in his place. Haitham first arrived to Beirut in May of 2014. Over the next four years, he would accompany Abu Samir to Beirut dozens of times. He handled or assisted in all purchases of medicine, visas, and plane flights. He occupied a stool next to Abu Samir's chair in the midst of chemotherapy treatments at the American University of Beirut Medical Center (AUBMC). The cross-border situation essentially removed the home and kinship network as the point of return after appointments. To be a *murafiq* was no longer primarily a matter of transport and protection; the role now encompassed the full range of attending to Abu Samir's illness-related needs, including his meals, bedding, vomiting, clothes, and emotional swings. Every 20 days they traveled from Salahadin to Beirut, remaining for up to five days. This chapter will explore how the temporality of the *murafiq* role shifts when long-term and repeated travel across international borders removes the domestic point of return.

If the shift into this cross-border role was not already enough of a change for Haitham, the family's violent eviction from Salahadin by militias further complicated

matters (*see* chapter 3 for the displacement journey). Haitham had to remain with Abu Samir and continue with treatments amidst displacement and gradual relocation from Salahadin (central Iraq), to Baghdad, and finally to the northern province of Erbil. After resettlement in Erbil, they resumed regular Iraq – Lebanon itineraries, with Haitham serving again as the *murafiq.*

In Beirut, Haitham found himself amidst a whole host of other men carrying out similar tasks. Haitham matched the profile of most *murafiqeen* in Beirut: They were adult males between 18 and 40. They were farmers, policemen, soldiers, firemen, mechanics, and government bureaucrats. They were men. As the range of tasks associated with the *murafiq* function expanded, Haitham would turn to these men in order to render the role bearable.

Male Caregivers and Companions

The heavy emphasis on transport and coordinating logistics in Haitham's role would, on the surface, seem to align with a number of previous studies on male caregiving roles. These studies have tended to suggest a gendered dichotomy between (male) participation in "managerial" affairs such as transport and logistics, and the (female) participation in the "nurturing" activities of cleaning, bathing, listening and empathizing. In fulfilling these managerial tasks, men care *about* the patient as an abstract problem but not *for* the patient in the responsive, nurturing sense associated with feminist care ethics (Montgomery and Kamo 1989; Pruchno and Resch 1989). More recently studies have questioned this framing and have sought to show that male caregivers often creatively blend the two dispositions towards caregiving (Russell 2001).

While Russell's insight helps us move away from a strict gendered binary between supposedly male and female functions, the notion of blending two distinct qualities of "managerial" and "nurturing" faculties still preserves a male/female dichotomy that is only helpful under a particular imagination of a caregiver.

The sense of the Arabic word *murafiq* does not align precisely with the English word "caregiver." Though used in hospitals across the Middle East to refer to the family member responsible for a given patient,[62] more broadly the word *murafiq* carries a distinct emphasis on partnership and accompaniment. For instance, the *murafiq* may refer to an attendant or helper to a nobleman – the person the nobleman most trusts in providing advice and help (Gilsenan 1996: 4-5). The root *r-f-q* connotes friendship and companionship. Another derivation of the root, *rafiq,* translates to "comrade" among Arab Marxists. An older usage of *rafiq* is that of the travel companion among fellow traders (Goiten 1971).[63] In the everyday spaces of hospitals, usage of the word *murafiq* is not the only way to indicate one's role as the companion of the sick. In hospital waiting rooms from Erbil to Baghdad to Beirut, Haitham and other *murafiqeen* use a possessive shortcut in relation to the patient to whom they are attending. In response to a question about one's purpose at the hospital or purpose for travel to Lebanon, a *murafiq* often

[62] A doctor or clerical nurse might ask, "Who is the *murafiq* of this patient?"

[63] Goiten described the medieval institution of the *rafiq*: "A particular type of commercial friendship was the institution of the travel companion, rafiq, mentioned in numerous documents and letters, but not yet sufficiently investigated with regard to its origins and history. People endeavored to travel in groups, large or small, but each individual traveler was specifically connected with another one by far-reaching bonds of mutual responsibility. Each was supposed to know the sums of money and description of goods carried by the other, to look after him in the frequent cases of illness or other mishaps, and to take care of his possessions after his death" (1971: 487).

responds, "I have a patient with me" (*'edi mareedh wiyaya*)[64] or "I came with a patient" (*Ijit wiya mareedh*). The simple assertion, "I am the *murafiq,*" is equally common. The two sets of expressions are aligned in conveying similar senses: Both emphasize accompaniment, the act of being with or journeying alongside someone else.

The temporality of the *murafiq* role is, under normal circumstances, circumscribed to the movements and labors of accompaniment outside the home. While the "caregiver" in Anglo-American contexts tends to be imagined as fulfilling labors of attending to the sick across the whole range of spaces where a patient may find herself (e.g., the home, the hospital, etc.);[65] the *murafiq* is understood to be the person who accompanies the patient beyond the confines of the domestic and engages with doctors and institutions on her or his behalf. It is an outward-facing and typically male role requiring transport, logistics, and interactions with officials. When Haitham returned home after day-long trips to clinics in Baghdad or Kirkuk, his *murafiq* duties effectively ceased and other persons took charge of Abu Samir's bedding, meals, medications, etc. The phrases utilized to refer to home-based care such as "he is concerned for me" (*howa yhtam biya*) or "he cares for me" (*howa y'tani biya*) do not align linguistically or conceptually with the *murafiq* function. The boundary between the outward-facing *murafiq* function and home-based care preserved a particular temporality of the role: The *murafiq* role was evanescent, circumscribed to a specific range of tasks.

In journeying across borders, the role of the *murafiq* is transformed into a potentially ceaseless range of tasks with unclear boundaries between on-duty and off-

[64] Speakers of *fousha* or Levantine dialects will note the unusual usage of *wiyaya* instead of *ma'i* to mean "with me" in the Iraqi dialect.
[65] The immense number of studies on "caregiver burnout" (Penson et al. 2000; Ybema 2002 et al.) emphasize the ceaseless labor of caregiving.

duty. The *murafiq* is, in this dislocated context, the person who attends to the patient's needs over the course of the trip. The removal of the domestic boundary defies the masculine norm of having daily time for "respite" (*raha*), and places *murafiqeen* in danger of never being released from the role. Yet, as I will show, the old boundary is reanimated in a different way in Beirut: Daily male sociality among fellow *murafiqeen* preserves spaces of 'non-work' and respite from their charges.[66] This 'non-work' is justified as a time or space when fellow *murafiqeen* can accompany and care for one another as men. Iraqi *murafiqeen* in Beirut accompany their patients *and* one another, forming lasting bonds with other companions of the sick.

Moreover, I contend that while this form of sociality allows a forgetting of the role of the *murafiq* and the constant grind of taking care of the ill, it simultaneously enables a collective remembering of the violence of males' lives under war. Departing from the literature on "homosociality" that emphasizes hyper-masculine and misogynist behavior (Bird 1996; Chen 2012), here the masculine space of non-work is primarily one in which *murafiqeen* engage one another as vulnerable subjects needing rest from turmoil and exposure to death in Iraq. This sense of care as male bonding takes us away from the dyad of the *murafiq*-patient relation to a broader web of companionship sustaining life and lives in Iraq. Ultimately, I suggest that repeatedly securing a boundary between "work" and "non-work" through male sociality reaches limits over the course of a long cross-border illness journey, again raising the specter of an expansive temporality of the *murafiq* function that borders on the unbearable.

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[66] Russ discusses how professional caregivers find small ways to set limits on the draining of their energies within the daily grind of providing care. They might distance themselves from a patient for a moment, and chat with co-workers while keeping an eye on a particularly draining patient (Russ 2005).

In pursuing these arguments, the chapter contributes to debates on the structural forces at play in the gendering of labors around the sick and vulnerable in transnational contexts of mobility. Western feminist scholarship has long sought to highlight the ways in which such labors are largely placed on the shoulders of women without remuneration. Any notion of gender equality must, Eva Kittay argues, recognize the fact that women spend much of their lives relegated to "dependency" work – i.e., mothering/rearing children and attending to the needs of the elderly, sick, and vulnerable (Kittay [1999] 2013). Recent studies have shown how these labors circulate across borders. Caring labors have become increasingly traded and consumed as transnational commodities, with females from the global 'south' providing care for the youth and elderly of the 'north' (Hochschild 2002). Care becomes an export that takes one away from one's home in order to care for the intimates of others.

Constable cautions, however, that the emphasis on the cross-border movements of women's care has elided male intimacies and masculine forms of care in similarly mobile contexts. She notes that we have yet to see ample "studies of men as intimate gendered subjects, as providers of care work and intimacy" (Constable 2009: 58). Studying men as providers of care for the sick and vulnerable is particularly important in contexts where women acting as the formal/institutional companions of the sick is the exception and not the rule. Because the figure of the *murafiq* is normatively male in Iraq, studying the transformations of this role under war and mobility can shed light on broader questions around the shifting labors and obligations of men.

Placing our attention on the caring labors of men does not mean that the central questions posed by feminist philosophers will cease to be important. One consistent

preoccupation among care ethicists is how to conceptualize the "care" of "caregivers." Kittay (1999) asks: What are the forms of practical support, financial compensation, and societal recognition needed for dependency laborers to endure the hardships associated with their roles? (Kittay 1999: 182-188). Again, the second section of the paper will argue that the *murafiqeen* seek out male bonding as respite from the daily labors associated with the accompaniment of the sick "abroad" (*bil kharij*) – engaging in a form of collective forgetting that in turn generates space for the remembering of the violence of life in Iraq. Yet, staking out this space for non-work is far from a durable solution to the problem of eroding boundaries, and the patient-*murafiq* relation remains volatile. In general, volatility characterizes the various scenes of care that I am describing across the chapter. Against the tendency to describe "care" as a long-suffering, durable, and affectively engrossing mode of responsiveness to the needs of vulnerable others (*See* Noddings 1984), I emphasize how illness accompaniment at home and abroad reveals the strangeness and ambivalence of relationships, and how this ambivalence takes on different shapes under conditions of mobility.

The *Murafiq* Role Across the Rural-urban Nexus

In what follows I will ethnographically render a span of four days, highlighting Haitham's work as a *murafiq* in everyday contexts in Erbil – the time in-between treatment trips to Lebanon. By 'everyday' I do not mean to suggest that their circumstances lack a sense of the exceptional or the extraordinary. Haitham, Abu Samir, and the rest of their kinship network are displaced (*naziheen*) and are residing in a world that is not their own. This set of conditions shapes the *murafiq* function in important

ways. Yet, as suggested in chapter 3, a fragile sense of everydayness has arisen out of immense labors executed over the course of a displacement journey. Amidst considerable turmoil both within and beyond the kinship network, they have reestablished spaces and rhythms of domesticity and agricultural work in a context of dislocation. Three farming households have retained separate budgets and operations under separate Kurdish landlords along the periphery of the Erbil-Kirkuk border – 25 kilometers from the nearest clinic and 50 kilometers from the nearest hospital. What is the temporality of the *murafiq* role in this particular setting?

Day 1: The Qoshtapa Clinic

It was around midnight. I was sitting with Haitham at his house (approx. 1 kilometer from Abu Samir's residence).[67] Abu Samir called Haitham's cell phone. "I need to see a doctor," he said. Haitham responded, "*Yallah* I'm coming." Haitham and I boarded the KIA truck and weaved back the dirt road to Abu Samir's house. Abu Samir's wife greeted us at the door. "He's been nauseous," she noted. Through the hallway I could see Samir massaging his father Abu Samir's thighs, a bodily practice that helped with the fatigue of chemotherapy. Abu Samir soon emerged from the concrete structure with a pronounced grimace on his face. "Pain, by God nausea," Abu Samir said. Haitham drove swiftly and kept his eyes and attention on the road. Abu Samir did not speak except to emit a few moans. I reached for the radio to turn on the music, and Haitham brushed my hand away. He nodded slightly towards Abu Samir and said, *dhooj* (annoyance, unsettling). We reached a makeshift checkpoint in the road. The Kurdish internal security

[67] In chapter three we discussed how Abu Samir and his two brothers maintained separate households in their displacement from Salahadin to Erbil.

(*asayish*) checked for proof of residency in the Kurdish Region. Haitham presented his identification. The officer nodded. We passed through the checkpoint without incident.

After 20 minutes we arrived to a clinic in the rustic outpost town Qoshtapa, and Haitham helped Abu Samir out of the car. We entered the clinic where a man with a white coat sat behind a desk. A certificate from the Kurdistan Health Syndicate hung behind him, verifying his status as a physician's assistant. With Abu Samir taking a seat, Haitham now leaned against a shelf of toothpastes, soaps, and bottles of aspirin. He fiddled with his phone, absorbed in chatting with a girlfriend from Salahadin. Abu Samir unloaded, "Doctor, I…" As Abu Samir explained his nausea induced by the chemotherapy, Haitham meandered outside of the clinic, continuing his conversation on the phone. He purchased a bucket of yogurt and four cartons of eggs at a store nearby and then returned. Inside, the 'doctor' administered a shot to Abu Samir while telling me about how the hormones from chickens, apples from Ukraine, and American bombs from uranium had contributed to an epidemic of cancer. Haitham waited just outside the door and chuckled every once and a while at the doctor's antics. Haitham quipped, "*Yallah* enough talking! Aren't you from Iran anyway?" The doctor laughed and kept jabbering away. The joke about Iran referred to the fact that most of the residents of the Qoshtapa area were Kurds of Iran who crossed into Iraq during the Iran-Iraq War.

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Let us review the scene briefly. When Haitham arrived to Abu Samir's home, Abut Samir was currently receiving a vigorous leg massage from his son Samir. Within the sphere of the domestic, the labors of attending to Abu Samir's needs were not strictly divided along gendered lines. Male and female family members cared for his body

(massaging, assisting with bedding, etc.), ensured compliance with medications, and offered him assistance with walking when needed. This overlapping of roles ceased beyond the edge of their threshold and plot. External relations, trading, and transport were the exclusive domain of male labor. This was a shared norm across the households of Haitham and his uncles. Haitham invoked a genealogical property in describing this feature of labor division: "In the house of Abdulrahman [the name of his grandfather], we're like this. Women don't drive or go out to the city without men or at least their permission." Under this gendered understanding of everyday mobility, which is increasingly widespread in Iraq, any illness-related task beyond the farm would require male accompaniment.

We must anchor our understanding about why people can move or work in certain ways within a historical scheme, particularly in the context of Iraq's wars, which have transformed gender roles in significant ways (Al-Ani 2008).[68] In longer interviews with Haitham as well as the female members of the household, this strict genealogical explanation was softened and historicized. Before displacement and prior to the entrance of US troops into Salahadin, women from the house of Abdulrahman would make short (walkable) errands to the nearby outposts to purchase items for the household. Or they would traverse the patchwork of roads in the neighborhood to visit neighbors. With the entrance of US troops into their town of Yathrib and the eventual proliferation of armed groups and militias, the men of the households placed greater limits on female mobility

[68] Al-Ani (2008) tracks how war and sanctions since 1990 have transformed the understanding of women's roles. UN sanctions brought about a huge shift, as scores of working women now faced dramatically reduced public sector salaries, and eventually had to leave the workplace to support domestic labor. Al-Ani suggests a general trend towards women occupying more traditional, less public roles, with limited mobility.

beyond the perimeter of the plot.[69] Men did not describe these restrictions in the language of protecting female honor (*sharaf*) but in the language of danger and ensuring "safety" (*aman*). The men professed a self-imposed limitation of their own mobility due to "fear" (*khof*). Haitham noted: "By God in Salahadin I didn't go out much, I was scared." In Erbil, the relative security that attracted them to the province in the first place was, simultaneously, a fragile reality maintained by unfamiliar and potentially threatening actors such as the Kurdish internal security (*asayish*). Haitham regularly interacted with security officials on the way to Qoshtapa or Erbil city for groceries, clinical visits, and other affairs. The tenseness of the roadway contrasted with the easygoing and sociable haven of the Qoshtapa clinic. Haitham and Abu Samir enjoyed a joking relationship with the Qoshtapa doctor and never hesitated to challenge his judgments to his face. Haitham's relative disengagement or inattention was a product of this lighthearted relationship. While doubting the man's medical expertise and credentials, they held him in a place of trust. He was "a great guy" (*khosh insan*) and acted with "humanity" (*insania*). A lack of formal credentials enabled a peer-like relationship. This was always the first stop in the medical referral chain.

Day 2: Cancer Hospital

The following morning Abu Samir's nausea remained. He called Haitham around 9am. "Let's go to the hospital." Haitham was already planning to venture into central Erbil. He needed to conduct some business at the market, which was very close to the public hospital. He picked up Abu Samir and me in the large KIA truck full of three tons

[69] In my surveys of rural displaced Arab farming families in the area, this historical awareness of constricted female mobility under conditions of war was not uncommon.

of lettuce. We made our way to Erbil's Nanakali Cancer Hospital at a glacial pace and arrived 80 minutes later, weighed down by the massive load. Dozens of people crowded around the front desk. Abu Samir looked at Haitham with a disapproving scowl. The receptionist shouted in a mix of Kurdish and Arabic for people to stand back. Haitham charged through the crowd to the back corridor where Abu Samir's oncologist was located. In contrast to the Qoshtapa clinic, here the relationship with medical personnel was adversarial. Haitham's body tensed up and he never left Abu Samir's orbit. He assumed the role of protector and negotiator. While charging through the crowd Haitham grasped Abu Samir's forearm too forcefully, prompting his uncle to protest, "Haitham leave it!"

Abu Samir's oncologist was not in that day. Haitham searched around for a nurse. He found the young female nurse from Baghdad that usually accompanies the oncologist. The nurse asked Haitham for whom he was the *murafiq.* Haitham nodded towards Abu Samir and described Abu Samir's symptoms in one compact sentence, knowing that he would have her attention only for a brief moment: "When he walks he falls," Haitham said, following, "So what medication can we take?" She kept walking, saying, "It's normal with the chemotherapy, just rest." Haitham looked to Abu Samir and said, *nanakhara.* The Hospital's name is Nanakali. Replacing the second syllable with *khara* (shit) always spurred a slim smile on Abu Samir's disgruntled countenance.

*

Public hospitals in Iraq since 2003 have become spaces associated with corruption and danger. At one end of the extreme in Baghdad armed gangs took advantage of the incapacitated states of enemies to execute targeted killings. Different militias and

political parties took over segments of the Ministry of Health (Dewachi et al. 2014). Erbil's public hospitals were generally regarded as safe from militias but not from the politicization of medicine. Abu Samir claimed that he was refused treatment dozens of times before finally obtaining admission into the hospital through the intervention of a Kurdish friend.

Much of the emphasis in the feminist care literature revolves around the notion of responsiveness to the "need" of the other (Noddings 1984), and that "need" is discerned – however imperfectly – through the expressions of ordinary language (Laugier 2015). The care literature has paid less attention to contexts and encounters where accompanying the vulnerable requires watchfulness towards threats in one's surroundings, a mode of attentiveness and protection that may preclude close attention to the other's every gesture and sensation. In Haitham and Abu Samir's case, these threats may include the obvious war-related actors such as militias manning checkpoints; however, here I have highlighted the subtler forms of institutional corrosion that generate a sense that hospitals are no longer safe havens. Haitham's grip tightened beyond what Abu Samir could bear.

Day 3: Street of Doctors

The following afternoon Abu Samir asked Haitham to take him to a clinic on "The Street of Doctors" (*shara atuba*) to inquire about the pain in his nose. We rode towards Erbil city but then circled around the periphery of the urban center in the direction of Mosul. First Haitham needed to take a quick detour to the farmer's market, the last major commercial hub before one entered the no man's land between Erbil and *daesh*-occupied Mosul. With Abu Samir remaining in the vehicle, Haitham disembarked into a stall where

tenant farmers from his home province Salahadin typically congregated to sell their produce. Haitham informed the group that he needed a quick buyer for his cabbage. He had other things to do, he noted, pointing up to Abu Samir. They all knew about Abu Samir's condition. Haitham lowered his sale rate slightly below the running 150 dinars/kilo that day, and a Kurdish buyer soon approached. The deal was made. Haitham labored to transfer the produce from his KIA truck to the buyer's KIA truck quickly.

Driving on the bumpy roads around the produce market, Abu Samir grabbed the edges of his seat and complained about the "moron" (*gowwad*) military driver who fell asleep and tumbled off the road back in the 1990 Gulf War, resulting in Abu Samir's smashed nose. "By God it's because of that man! What a loser! This disease is always in the same place!" Haitham slowed his pace ever so slightly, pronouncing emphatically *kheli walli* ("let him [the military driver] fuck off"). Abu Samir muttered again under his breath, *gowwaaaad*! Entering the smooth roads and wider lanes of the city center, Abu Samir noted the presence of two Kurdish women walking in the direction of our advancing vehicle. Just as he was beginning to comment on their attractive figures, Haitham cut him off, chuckling and exhorting him at the same time: "Abu Samir, just think about the afterlife and enough already! You're between life and death and thinking about women. Enough (*Khalas*)!"

We arrived to *shara atuba*, the Street of Doctors. The street consisted of approximately 4 blocks of clinics. Signs for specialists – heart, lungs, bladder, and teeth – dotted the sidewalks. There were no clinics for oncologists. In Erbil and Iraq generally it was illegal for oncologists to establish private clinics. Abu Samir wanted to see the general physician that had diagnosed his cancer three years previously. He trusted the

man who had finally discovered the disease after months of therapeutic futility and travel from province to province. Today the doctor was not in. Haitham called the cell phone number listed on the door. The doctor answered, informing Haitham that Abu Samir simply needed rest until the chemotherapy course was complete. We returned to the farm after making a quick stop to pick up some groceries. Upon arrival to the farm, Abu Samir stepped out of the truck on his own accord. The three of us entered the cinderblock structure. Abu Samir's wife laid out a mat and pillow for her husband and served us tea. Haitham then made a move to return to his plot. "I have work," he said. Haitham set off to his tomato fields. The irrigation valves needed checking before he could determine whether or not he needed to make another run to Qoshtapa.

*

Haitham, as this scene indicates, was perpetually a man of the roadways. His role as the family's driver, seller, purchaser, and negotiator overlaps with the transport of Abu Samir to the various clinical sites. Above we see that Haitham makes small purchases and performs business-related tasks while shuttling Abut Samir from clinic to clinic. He purchases yogurt and eggs for the home. He sells three tons of cabbage. These small errands and tasks are possible largely because the medical and commercial geographies of Erbil province overlap. The town of Qoshtapa sources agricultural products as well as primary medical services to the farmers and refugees residing on the outskirts of Erbil. In central Erbil one finds the farmer's market as well as public oncology centers and advanced private clinics along *shara atuba.* Haitham likewise transported other family members to clinics for illnesses and injuries incurred on the farm. During my several months of fieldwork at the farm, Haitham received phone calls for driving assistance for

the following: His uncle Abu Haamid's 6 year old-son Ahmed tripped under a rickety boiling pot of milk and received a severe burn; his uncle Abu Samir's wife's eyelids and cheeks were burned from stray boiling oil; Salam dealt with chronic back pain; one of Abu Haamid's granddaughters was run over by a loading truck, eventually dying from the injuries; one of Abu Haamid's sons had a skin rash and fading hairline on his scalp, which the doctor speculated emerged from the generator fumes. Haitham would first drive the afflicted person to Qoshtapa, a small town 25 kilometers away with a spattering of pharmacies and clinics serving the local Syrian Kurdish refugee population. If the remedy at Qoshtapa was deemed sufficient, they would return home to the farm. If the matter required closer attention, Haitham would continue on towards the Erbil city center (approx. 50 kilometers from the farm). The city center hosted higher-level clinics along "The Street of Doctors" (*shara'a atuba*) as well as several public hospitals.

The roadways brought together etiological associations that encroached upon the scene of care and accompaniment. The bumpy roads encircling the farmer's market butted up against a borderland between Erbil and Mosul. The farmer's market was the last point on the road one could travel before generating suspicion of intent to access *daesh* territory. As such, these pathways were poorly maintained and the car shook as we traversed them. For Abu Samir, the rutted "roadways" (*turuqat*) had a tendency to generate connections with similar experiences of failed roadways, including the fateful tumble off the road during the 1990 Gulf War resulting in the nose injury. More than generating a memory of an event in 1990, the road conjured up a feeling of distaste and anger towards a negligent individual – the *guwwad* driver. Recognizing this set of emotions as unsettling for Abu Samir, Haitham's slightly slowed pace and emphatic

pronouncement *kheli walli* were calibrated towards brushing the association aside without implying negation of its veracity. *Khelli walli* (let him wail, let him fuck off) is a flexible term. Among tenant farmers, the phrase is often used to encourage evasion of landlords' commands without authorizing direct confrontation or disobedience. For instance, a child might protest, "The owner of the farm called and said I have to come over and de-weed his plots!" To that, an adult could respond, "*Kheli walli*, he'll come get you if he really wants you." In other words, let the matter drop for now until you absolutely have to confront it. *Kheli walli* is both decisive and supple. Let your etiological preoccupations drop – for now.

Linda Hunt's research (1998), which I referenced previously, shows how women breast cancer patients often attributed cancer to a *golpe* or "blow" from her husband. Hunt understands these "views" as cultural models "directed at a single end: denying the arbitrariness of suffering by associating it with antecedent events and thereby sustaining the idea that the world is indeed essentially orderly and controllable" (Hunt 1998: 311). Hunt's analysis presumes that etiologies are stable belief systems emerging from subjects' needs for meaning. Hunt accesses these "views" through interviews and narrative analysis. In the scene above, we see how the rutted roadway thrusts a series of associations upon Abu Samir. Haitham's response indicates his sensibility towards the fact that etiological associations can contribute to disorder and discomfort just as easily as they can contribute to clarity and cohesion. The work of caring and accompaniment becomes one of encouraging evasion of these etiological incursions without failing to acknowledge their power. He says, *Khelli walli* (let him fuck off).

Day 4: Preparing for Travel

The next day it would come time for Abu Samir to go to Beirut for a round of chemotherapy. During the morning hours, Abu Samir made a flurry of phone calls to his nephews and brothers with instructions regarding the sale of his product in his absence. He firmly instructed them not to sell for anything less than 120 dinars per kilo, regardless of whether people accused them of being "dry" (*yabis*). He made consultations about arranging for some day "workers" (*'ummal*) to provide relief in his absence. Then he called Haitham, saying emphatically: "*Yallah* let's go!" We boarded the truck of Abu Samir's younger brother – now brimming of 4 tons of watermelons. The weight of the car would translate into an excruciatingly slow pace on the road. During the 80-minute trip, Abu Samir and his younger brother bickered about the quality of the day laborers that the latter had arranged to provide support in Abu Samir's absence. Abu Samir hurled: "You got me children and two women! You call that helping? By God I'm thinking not even to pay you back for them!"

Haitham did not intervene in the spat between his two uncles. He showed me some photos of horses and tigers amidst Quranic backdrops on his phone. Haitham's subdued comportment contrasted with the heightened alertness of his uncle, whose energy soared throughout the duration of the car ride to the airport. Abu Samir made and received several phone calls: "How are you my friend! How are you! Blessings on you, where are you now? By God we are harvesting water melons….You know how much water melons are selling for in Kirkuk? 160, 160 (dinars)." Then Abu Samir called his nephew Hammoudi (Haitham's brother): "You hear? 160! Don't sell for less than 160 or by God I'll come after you." Hammoudi's distinctive voice blurted out from the phone,

"Enough already! This is my work (*hay shughli*)!" As we approached the airport gate, Abu Samir dawned a breathing mask and placed his phone away. Haitham readied the bag and passports. We stepped out and entered the terminal.

*

Haitham's duties as the *murafiq* unfolded alongside other roles related to Abu Samir's illness and periodic absence. Leaving the farm and field behind placed the governance of Abu Samir's plots on others. Haitham played no major role in coordinating these arrangements. He sat disinterested while Abu Samir cajoled and gave orders to those who would operate in his stead. Abu Samir's nephew Hammoudi (one of Haitham's brothers) took up responsibility for selling and hauling his produce. Abu Samir's eldest son and second wife effectively took over the supervision of harvesting, planting, watering, packaging, and all other field-based agricultural activities. His younger brother arranged and coordinated day laborers to supplement the family's bodies. Most of Abu Samir's advice prior to departure was directed towards Hammoudi, scolding and cautioning him against low-selling.

The list of instructions and reprimands irked Hammoudi. His protest *hay shughli* (this is my work!) was both an assertion of competence and commitment. One's "work" (*shughl*) was, among tenant farmers, the range of labors for which one receives a cut of the profits. When landlords requested favors or duties falling outside the tenant's plot or beyond agricultural production (e.g., plowing *donums* farmed by the landlord's family, construction projects, road maintenance, etc.), the tenant could justifiably protest, "that's not my work" (*hay mo shughli*). Usually these protests were muttered under one's breath instead of to the landlord's face. Diplomacy was paramount in landlord-tenant

relationships, particularly among the Arabs displaced to Kurdish Iraq. (As noted in chapter 3, expulsion represented eviction from one's plot and potentially the Kurdish region as a whole.) Diplomacy was also paramount in relations between Arab tenants and their subcontractors. It was not uncommon for tenants to contract day labors – also displaced Arabs – to supplement field capacity and "drivers" (*karwa*) to haul/sell one's produce. These actors were paid a fixed rate, typically 10,000 dinars/day for day laborers and 25,000 dinars for hauling or selling a single load. The figure of the day laborer or driver was always suspect. Because they did not receive a cut of the profit, it was not their "work" (*shugl*) and presumably they would not exert much effort. Hammoudi's assertion "this is my work" (*hay shugli*) was intended to distinguish between himself and the paid "driver" (*karwa*). While he would not receive a cut, he would sell the product *as if* it were his own and therefore maximize gains. Hammoudi would often make this assertion explicitly, "I sell Abu Samir's crop like it's my crop. I don't hurry it."

Abu Samir's litany of instructions to Hammoudi en route to the airport signaled a decisive break in everyday modes of communication. In traveling to Beirut, Abu Samir's phone mostly remained in his pouch, effectively removing himself from day-to-day agricultural affairs for the duration of the trip. Haitham similarly broke off agriculture-related communication upon arrival to the Erbil airport. Whereas he mixed agricultural and *murafiq* errands in his trips between home and the local hospital in Erbil, Haitham's "work" (*shughl*) as a *murafiq* abroad would be confined to Abu Samir's "treatment" (*'ilaj*). Others would have to attend to the plot back home. Let us explore the nature of Haitham's "work" abroad.

A *Murafiq* in Beirut

In the upcoming sections I will look at two of Haitham's trips to Beirut – one during the summer of 2014 and another in 2016. I will suggest a gradual evolution of Haitham's *murafiq* duties between the two trips. I will explore why this evolution occurs. When I accompanied Abu Samir and Haitham to Beirut for treatments in 2014, Haitham's labors unfolded according to a set of specific day-time and night-time routines and practices. During day-time appointments to the hospital, Haitham largely remained at Abu Samir's side and cared for the needs of Abu Samir's body. He engaged with doctors, pharmacists, and other medical personnel. There was no discernible attempt to avoid certain tasks deemed feminine. Whilst in the hotel room, he participated in assisted in cleaning Abu Samir's vomit, helped him into the bathroom when necessary, rubbed his legs to assuage the pain of chemotherapy, etc. These tasks were new and occasionally burdensome to Haitham *not* because they were marked as feminine but because Haitham's *murafiq* duties in Iraq typically ceased when he returned Abu Samir home from the hospital. In Iraq, the structure of the *murafiq* role placed limits on the range of duties.

Yet, Haitham preserved boundaries between "work" and "non-work" through other means. During the evenings, he took advantage of every opportunity to forge new relations or "friends" (*asdiqa*) as he called them. He bounced across the city's several cafes looking for interactions with fellow Iraqis. He developed friendships with the dozens of *murafiqeen* and a few able-bodied male patients, spending several hours daily "hanging out" (*gaideen*) with the "guys" (*shabab*). Young male *murafiqeen* traversed the

city and enjoyed city benches, beaches, and even bars and clubs. These social outings forged both large groups of *shabab* and strong dyadic pairings: Haitham spent most evenings with a man named Mohanid from Baghdad. They fished on the Corniche; they assisted one another with each other's pharmaceutical errands; they strolled the city. Mohanid was a mid-level employee in the Ministry of Agriculture. In terms of social class and education, the distance between Mohanid and Haitham could not have been greater. Mohanid's brother (and patient) was a prominent judge in Baghdad's counterterrorism court. Beirut brought together *murafiqeen* of widely varying social backgrounds into unlikely friendships, cutting across social and ethnic divides.[70] Haitham and Mohanid's bond was strong but not exclusive. Other *murafiqeen* often accompanied them on their journeys through the city.

The issue of specifically male modes of bonding has become an important theme in anthropological and sociological studies of masculinity. One line of argumentation in these studies has been to theorize homosociality as sites of exclusion for the defense of male norms and male hegemony. Paul Willis (1977) describes a group of working class boys who form a tight-knit male order that excludes anyone not associated with the assertive masculinity of the working class male. Enjoying a "laff" with one's close mates is an expression of solidarity and of resistance against middle class authorities, women, immigrants, and men who fall outside the working class set of norms (1977: 14-15). A number of studies take a similar approach to the theorization of homosociality,

[70] There is often a notion in friendship studies that such relations often "transcend the divisions imposed by such collective mechanisms of inclusion and identity as kinship ties, settlement membership, or ethnic affiliation" because they are "dependent on personal affinities," and simultaneously because friendship across lines of difference forge alliances with "potentially dangerous others" (Santos Granero 2007: 13).

highlighting how collaborations and friendships with other men result in the defense of gender order and patriarchy (Bird 1996). A hyper-masculine and homophobic vocabulary dominates these interactions in order to establish the hegemony of male norms and to suppress any encroachment of sexual desire (Chen 2012). Under this understanding, male bonds are forged *not* through intimacy but rather through exclusion.

Hammaren and Johansson (2014) provide a helpful critique of this formulation of homosociality:

> "This common use of the concept – which refers to how men, through their relations to other men, uphold and maintain patriarchy, in terms of emotional detachment, competitiveness, homophobia, and sexual objectification of women – tends to reduce homosociality exclusively to a heteronormative, androcentric, and hierarchical term used to show how heterosexual men bond and defend their privileges and positions. Is it not possible to discuss, for example, male homosocial relationships in terms of intimacy, gender equality, and non-homophobia without disregarding the possible advances of maleness?" (2014: 6)

Hammaren and Johansson (2014) are concerned about the dangers of repeating the trope of homosociality-as-domination. Their proposal is to analyze both the *vertical* and the *horizontal* aspects of homosociality with equal seriousness (2014:6-9). The vertical dimension refers to the exclusionary, dominating quality of homosociality. The horizontal dimension refers to the ties of intimacy and closeness enjoyed by men. Hammerson and Johansson reject the notion that homosociality is fundamentally defined by a lack of intimacy and the reliance upon exclusionary practices to forge relations.

Indeed, the activity of male "hanging out" (*gaideen*) was often justified as *raha* (respite) – respite from chores, from women, etc. But the term *raha* took on a dual emphasis. As I will show, Haitham, Mohanid, and the other *murafiqeen* constantly spoke of "Iraq" as an external entity to which they would inevitably return, but from which now they enjoyed a moment of "rest" (*raha*). This *raha* was characteristically male not only in its exclusion of women but also in its envelopment within discourses of male vulnerability to death in Iraq. The *murafiqeen* talked about their lives as constantly subject to explosions, kidnappings, and economic disaster. They spoke of their fears and doubts about the future. We can recognize the exclusionary and patriarchal aspect of male bonding without eliding the forms of intimacy and closeness, mutual dependence, and victimhood.

The next several scenes document encounters between Haitham, Mohanid, and other *murafiqeen* in the summer of 2014. At this point Haitham had only travelled to Beirut three times. His newfound "friends" were likewise relatively new to Beirut. I have not rendered the conversations among *murafiqeen* verbatim. These encounters lasted for several hours at a time. Instead I describe the overall arch of the encounter and highlight key exchanges and speech acts.

Going Out

It was 9pm. The young male *murafiqeen* convened in the lobby of the Hamra Star Hotel. It was time to "go out" (*yshar*) and leave respective charges behind for an hour or two. Now I was walking down Hamra Street with Haitham, Mohanid, and another *murafiq* named Omar, a policeman from Mosul. We passed the Starbucks to our right, and

the H&M to our left. We passed a juice bar, a newspaper stand, and a string of money exchange booths. We walked shoulder to shoulder, making slight crevices for other pedestrians to pass through us. Meanwhile Omar texted with a "girlfriend" he met in the waiting room of the hospital. Haitham and Mohanid expressed their skepticism about the budding relationship, alleging that surely she was a prostitute (*gahbah*).

We were en route to Rouche, the site of the famous and picturesque Pigeon Rock. Pigeon Rock was tacitly considered to be the outermost acceptable limit for those who wanted to remain within a reasonable distance of their patients in the event of an emergency. Mohanid observed with a serene look, "It's so nice to be able to walk out at night right?" Omar nodded affirmatively, saying, "You could never do this in Mosul at night." As both men were city dwellers – Mohanid hailing from Baghdad and Omar hailing from Mosul – they both had to deal with the imposition of curfews by Iraqi Army units. Omar elaborated, "I could almost relax here in Beirut and forget Iraq completely, if only for the fact that my family in Iraq isn't safe, is never safe." Haitham inserted a nostalgic register, "By God we used to go down from Yathrib to Baghdad…You could sleep in the street. But now I just drive down to sell produce and go right back to Yathrib. I don't go around, I get scared (*akhaf*) to go out." Omar added, "It's a tired situation (*wadha ta'baan*). I've gotten weary even of life itself (*maleyt hata min al hayyat*)." Finally Haitham inserted, "By God Iraq is a problem. There's no rest" (*mako raha*)." We arrived to the Pigeon Rock and stared in silence until a vendor with a polaroid camera asked to take our picture. Then Mohanid received a call from his brother requesting that he purchase a painkiller at the pharmacy. We headed for the Wardieh Pharmacy.

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Hammaren and Johansson's (2014) notion of vertical (patriarchal, hyper-masculine) and horizontal (intimate) dimensions of homosociality provides an opening into this scene. Certainly above we can see how male friendships marked out a space for a certain discourse about women. Omar's talk of his Beirut girlfriend met up against the skepticism and playful responses of his companions. In general, the nightly chats among the *murafiqeen* often generated social encounters where banter and bragging of girlfriends and wives could receive a welcome hearing. While this was a space where masculine forms of talk and jokes about sexual exploits could unfold uninhibited, this was by no means the dominant mode of conversation. The exchanges above turned from talk of girlfriends to assertions of shared vulnerability, weariness, fear, and anxiety. "Iraq" was invoked *in contrast* to Beirut. Iraq was a "problem" (*moshlaka*), a site of early curfews and fearful mobility. Beirut's streets were "nice" (*helo*) and furnished the ground for an easy stroll. Yet *raha* (respite) was not complete: Beirut was *almost* a place of genuine rest and relaxation, if not for the fact that loved ones back home continued to live in danger, and if not for the fact that their patients beckoned.

Remembering Violence

In part due to my presence, the subject of Americans and particularly American soldiers were a common point of discussion. One evening we set out towards the Zaytuna Bay Harbor. It was Haitham, Omar, Mohanid, and another two *murafiqeen* named Ibrahim and Kawa. We had nearly reached the other side of the hospital when a cohort of Iraqis past us by, half of them wearing medical breathing masks and two in wheelchairs.

Gesturing towards the battered group, Omar said with a regretful smile, “By God your group destroyed us ya Mac” (*jama’tak kharabtoona*). But then his speech slowed and he muttered: “The Americans, there were things that were, well, *mo bashir* (not human).” He didn’t elaborate.

Kawa filled the silence: “No the Americans. Some of them were good. Some of them, especially the Marines, they were not…”

Ibrahim, who was sipping on a plastic bottle of vodka, interjected: “One night I was walking down the street in Baghdad. Just like this hour more or less. I had drunk about 3, maybe 3 and a half bottles of vodka. There was a tank. It was Americans, and I am walking straight at them. They shine the laser on my head. Now the tank is about the distance between us and BarBar [A fast food restaurant in Beirut]. I keep walking because I’m drunk of course. Then they tackled me to the ground and gave me water and bread, and they all laughed for a while. They took my number and told me to be on the lookout for extremists. They told me that they were about to shoot me, but one of the guys, a soldier, a black guy, he said: ‘Look, he’s carrying liquor in his hand. He’s drunk, don’t shoot.’ Then they gave me the card, a card that could get me anywhere in Baghdad, including the Green Zone. But now it’s useless. I get scared about going out.”

My instinct here was to chuckle at the absurdity of his fortune, and I did. But none of the other *murafiqeen* showed any hints of a smile. They received the story with nonplussed expressions and kept staring ahead at the sidewalk.

Haitham added, “The Americans, they liked it if you insulted them. They’d say, ‘this one is honest, he insulted us.’ Some Americans came up to me and to my uncle and asked if we had any guns in our house. My uncle said, ‘Yes. We do. We have two, and we

won't give them to you because you've made everything so unsafe that we have to protect ourselves.' By God they kept going, and then they would always ask to sleep in our garden, which was, of course, it was dangerous for us. We were always afraid of retribution."

*

Walking through Beirut thrust small recollections upon the group of *murafiqeen*, and in turn they used the urban landscape as a stage for their stories. Accounts of encounters with American soldiers revealed the absurd criteria of survival. Ibrahim had the good fortune to be drunk enough for his disheveled appearance and clanking vodka bottle to reveal himself as *not* a suicide bomber nor an insurgent but rather as someone with values and interests aligned with the soldiers themselves. They granted him protection for his strange feat, but of course this protection only lasted as long as the Americans remained in Iraq. Haitham likewise indicated the bittersweet victory of gaining the favor of American soldiers. Haitham and his kinsmen were savvy enough to "insult" their questioners in order to prove authenticity, but they then could not refuse the presence of the American boarders whose trust they had won.

Not Human

Omar did not elaborate on his earlier comment about *mo bashir* (not-human) actions of the Americans until the group had largely dissipated and returned to the hotel for sleep. Now only Omar, Haitham, and I remained out. The three of us strolled by a parked Volkswagon van on Hamra Street near the Starbucks. Omar noted in passing how our distance to the van was the "same distance" as an "entire family" he witnessed perish

"in an instant." Haitham queried, "Was it an armored car?" (*chan mutdara'?*). Omar nodded and continued, "I was doing a patrol. Stationed on the sidewalk. An armored car, they came down the street. *Wallah* there was room to go around! There were two lanes. But they went over this family car. Killed them all." Omar's speech slowed again and uttered, "It was something, well it was not-human" (*mo bashir*).

Omar recounted how the accumulation of so many incidents eventually resulted in his body revolting against him. "I couldn't move myself to get up, to get out of the house, I turned my phone off." When the commander would ask his family about Omar's whereabouts, they would report that he was in Erbil. Omar explained, "My situation wasn't stable (*wadhi' ma chan mustaqir*)…I couldn't handle it" (*ma chinit agdar athamil*). The refusal to report to the station ultimately resulted in his imprisonment. Omar broke down into laughter when reflecting upon the absurdity of his fall from grace:

> "I went before the judge and started going off on how things have been tough at home, and my mother, she had a stroke, and what not. He looked over the bench and lowered his glasses saying, 'you're not a government employee. I don't want to hear about your domestic issues. You're a policeman. Off to prison!!!' You wouldn't believe the kind of people I was with in prison. The first guy I met was sleeping and his gun was stolen from him! What a failure! That's a big fine and imprisonment. Losers! And I was right there with them! I was there for 2 months and I wanted to kill myself. So what state would you be in if you stayed for a year, 10 years?"

Omar then elaborated that upon release, he returned to the force with the understanding with his commander that he would facilitate an early retirement within a year. But then

one day he was driving with another policeman and they drove over a landmine. The explosion sent shrapnel into the passengers seat and killed Omar's fellow officer instantly. Omar was left with nothing more than a few cuts on his right side. Omar started paying his commander bribes in order to stay at home. Ultimately, they granted a temporary release from duty. As soon as he found a way out of the police force he confronted a lack of purpose. He ended his account by telling Haitham and I, "Police work, this is what I was made for. The state has to return."

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Omar's repeated usage of the broken colloquial phrase *mo bashir* (not human) instead of a ready-at-hand formal phrase such as "inhumane" (*gheyr insani*) indicated the incoherence of the affects, recollections, and bodily responses he was experiencing. Beirut was, for Omar and many *murafiqeen*, a brief pause from a "weary situation" (*wadha'a ta'baan*) in Iraq. Relations with other *murafiqeen* enabled a mode of processing and reflection among fellow listeners who shared similar experiences yet who, importantly, would not contest or reframe each other's accounts. Haitham and I nodded and nothing more as Omar conveyed his story. This tendency to listen without a response contrasts with previous depictions of masculinity in the Arab World. Julie Peteet (1994) has argued that, because the vulnerability of Arab Palestinian men to violence defies a masculinity (*rujulah*) rooted in "expressions of fearlessness and assertiveness (1994: 34)," violent beatings at the hands of Israelis must be rendered culturally acceptable through reframing this abuse as a ritual passage from boyhood to manhood. Among the *murafiqeen* in Beirut, mutual acknowledgement of male vulnerability to violence is shared without an attempt to align it with notions of *rujulah*.

But back at the hotel, Omar's occasional attempts to recount his past received pushback from his cousin, a leukemia patient, who held general antipathy for the police and provided alternative versions of the events of the American Occupation in Mosul. Nightly separation from the realm of kinship enabled forms of recollection that would not otherwise be possible. Haitham and the other *murafiqeen* allowed Omar to speak in a monologue, while Omar's cousin insisted upon a certain polyphony (Bakhtin 1984) – a story with multiple voices that are never subsumed to a broader narrative. Friendships among *murafiqeen* involved giving way to each other's narratives of war and letting them stand as is.

Brond (2017) argues that the Syrian Civil War has generated spaces for new forms of friendship and intimacy. Brond argues that these friendships have been freed from the everyday back-biting and one-upmanship of pre-revolutionary bonds. War and revolution generate new spaces of social gravity, liminal environments in which relations are pulled out of the everyday (Brond 2017). In contrast, the male sociality I am describing does not wipe clean the slights and tensions that characterize everyday relations. While indeed war and dislocation had brought together groups of male caregivers into a common space, *murafiqeen* like Haitham, Mohanid, Omar, Kawa, and Safa were not above gossiping about or disparaging one another along regional and sectarian lines. (Kawa, a Kurd, often chided Omar and Sunni Arabs generally for exhibiting excessive resistance to the Americans in cities such as Mosul and Ramadi.) These slights did not disrupt or unravel the lines of care connecting the *murafiqeen*, however, which again drew force and

substance from the mutual acknowledgement of a shared vulnerability and history of war.[71]

Departures

A group of the *shabab* congregated at the Hamra Start Hotel. It was a night of departures. "My head isn't clear" (*rasi mo safi*), all of my friends are leaving tonight." Haitham uttered these words as he noted the departure of Mohanid, Omar, Kawa and a few others. They were returning to Iraq. Haitham was particularly distressed about the impending parting of his good friend Mohanid. "We were always together," he said while Mohanid nodded and added his own statements of affections. Later in the evening Omar likewise added similar sentiments, referring specifically to his friend Kawa, a Kurdish *murafiq* with whom he had developed a particularly strong relationship. "There's no one like Kawa, no one with whom I can be bound" (*murtabid*). The group planned a stroll to Pigeon Rock for a final night out. Haitham declared, "We won't sleep tonight!"

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It was especially surprising to hear Omar state and restate these words of affection to his friends. *Daesh* had invaded his hometown of Mosul a few days prior to this exchange, yet his attention seemed squarely fixated on the friendship to be lost in the present. Departures of fellow *murafiqeen* always generated a social event. The *shabab* absolutely had to "go out" (*yshar*) on those nights. Complaints of bodily afflictions,

[71] Hayder Al-Mohammad (2016) makes a similar point in an interview, describing an Iraqi acquaintance he had recently met who helped him with his stalled car in Madison, Wisconsin: "What is it that ties an atheist Iraqi (me) with a Sunni from Ramadi living in Madison? It's not a discursive tradition; it isn't even nationalism. In some sense, we both share an understanding of life and living under war, the experiences of sanctions, and so on…"

including headaches and stomach problems, often accompanied the departures of the guys. Haitham complained of a hurting colon when Mohanid finally left.

The force and emotional impact of these departures was significant. As I struggled to understand these affects and asked the *murafiqeen* to explain them, I always received similar answers: In Iraq, they had endured so many deaths, so many departures. Usually these lost friends were counted in specific numbers. "I lost 120 friends," Kawa once said. The sudden cutting off of a friendship forged in Beirut produced a similar effect. Due to the ethno-sectarian dynamics of internal roadways in Iraq (mediated by militia-run checkpoints), these budding relations and ties were unlikely to unite in Iraq for quite some time. The *murafiqeen* always called one another upon return to Beirut and inquired about each other's presence. "Where are you, are you here in Beirut?" It would be more likely to convene in Lebanon than back in Iraq.

Russ (2005) notes how the hardships of care can retrospectively be transformed into a "gift" through a conversion from language of expenditure to the language of profit. Long-term caregivers of sick loved ones might insist that they "gained more" than they gave in the form of toil (Russ 2005). Haitham and the other *murafiqeen* do not conceive of caring toil in the language of expenditure, and likewise its reversal does not operate along the lines of expenditure/profit. For Haitham, periods of accompanying Abu Samir in Beirut became retrospectively associated not only with hardships of care but also with the wide array of relations with other *murafiqeen* forged. The enjoyment of "respite" (*raha*) in the presence of others in Beirut could in some instances take on a dynamism and excitement that rivaled or exceeded *raha* back home. The absence of the shroud of violence and the rich assortment of persons drawn from the country's 18 provinces

generated a unique, albeit ephemeral, sociality. Upon return to Iraq, it was not uncommon for nostalgic statements such as “Beirut was full of friends” or “Beirut were nice days” to be situated alongside expressions of hardships associated with financial burden and labor.

Limits of Male Sociality

Over months and years of travel back and forth between Iraq and Beirut, the weight of these departures gradually accumulated and impacted Haitham’s willingness to engage and re-engage in new ties. Moreover, mounting financial pressures of treatment in Beirut weighed down on Haitham and the wider kinship network. Haitham, as noted in chapter 3, reached the end of his capacities to advocate on behalf of Abu Samir. With each return trip and the costs associated with them, Beirut became part of the broader experience of war-related suffering rather than a relief from it. Haitham’s repeat trips to Lebanon lost their social vibrancy. He forged acquaintances, but never friendships that would risk another rupture-like departure. He would call Mohanid and Omar and others upon arrival to Beirut’s airport, asking if they were currently in the city. But they rarely were, as treatment itineraries did not typically overlap.

As he spent less and less time “hanging out” (*gaideen*), he spent more time with Abu Samir in the hotel room. The problem with the narrowing of his social orbit was that it rendered his “work” (*shughl*) as a *murafiq* endless. He complained vociferously of having “no respite” (*mako raha*), and of being repulsed by Beirut. Over time this overall draining of social energy sapped his spirits for the outward facing aspect of the *murafiq* role. He turned his attention to Abu Samir’s most immediate expressed needs, but did not have the force to engage doctors, hotel owners, and other agents. He remained at Abu

Samir's side constantly; yet, in doing so, rendered himself incapable of fulfilling the full range of duties placed on his shoulders. Abu Samir gradually took over the outward facing functions of the *murafiq* role.

In a 2016 interview, I asked Haitham about the extent of his Beirut "friends". Without hesitation, he listed them off:

> "Well first there's Mohanid and his brother Abu Khadham from Baghdad. Mohanid and I have a very strong relationship (*ilaqah hel qawi*). From morning to night I was with Mohanid in Beirut, and he still calls me (*khabirni*)…Then there was Hamdan, an engineer from Basra, who was always helping everyone…Abu Sara from Baghdad, a mechanic. We talked to each other a lot over the phone. And there was his brother Hussein, from Diyala…Ayman was from Najaf. He worked with aluminum windows. He was with his sister. Abu Jassim was from Baghdad, he was there in Beirut with his wife. He was an employee in the Ministry of Health...Omar was from Mosul, with his brother. Omar was police..."

Thirty-five names later we reached the end of the catalogue. He noted occupations and specified the frequency of contact. With the exception of two individuals, all of Haitham's ties were forged during the first five of fourteen trips to Beirut. What were the consequences of the draining of Haitham's social energy? Let us examine a Beirut trip from 2016:

Arrival

We arrived to Beirut in June 2016 for a round of chemotherapy. Haitham followed behind Abu Samir as we proceeded to the curb. Abu Samir took control. He passed up the

first dozen or so taxis. He approached the taxi windows, one after another, and asked for 10,000 Lebanese Lyra (LL) to the Hamra district, which seemed to me like an impossibly low bargaining position. Soon he found a taker for 15,000 LL. The elderly driver noted Abu Samir's facemask and enthusiastically pronounced *Salamtak, Salamtak hajje* (Your health, your health, old man). He continued, "You know *hajje* my wife is sick too, my daughter is sick, I was injured in the April War (*harb tammouz*)." Marking himself as a Hezbollah fighter, he held up his punctured and twisted forearm as proof, and claimed that he had recently taken his entire afflicted family to the steps of parliament to shame the politicians for their ineptitude. As we passed by Hezbollah-controlled Dahieh and proceeded into the lower areas of downtown, the driver continued his wide-ranging political analysis: "*Daesh* those dogs I hope they'll be flattened all of them in Iraq! By God, we Shia, you don't see us blowing ourselves up, do you?" To this Abu Samir responded, "Sunni, Shia, we are all one." Haitham kept his eyes fixed on the conversation unfolding in the front seat but did not intervene directly.

Beirut's Hamra Star Hotel now stood before us. Abu Samir charged inside and shouted commandingly, "Abu Wissam!!!!! Where are you?" A portly man peered out a small office and welcomed us in, "*Ahleeeeeeeeeeen*," (Welcoooooome) he said with a grin. Abu Samir stated his intention to stay no more than two nights. Abu Wissam quipped, "Did you come here for night clubs or for treatment!!!" Haitham stood to the side while Abu Samir made the deal and handed over the cash. Haitham did not laugh at Abu Wissam's joke. He ascended to the room and went to sleep without making any visits to the local hotspots for encounters with other *murafiqeen.*

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Beirut's International Airport is situated adjacent to the Hezbollah-controlled territory of Dahieh, and this particular taxi driver hailed from that neighborhood. Given that Abu Samir's home in Salahadin was currently occupied by militia elements affiliated with the Iraqi Hezbollah Brigades, one would expect a certain degree of apprehension on the part of both Abu Samir and his *murafiq* Haitham towards this battle worn veteran of the April War at the wheel. Haitham kept his eyes fixed on Abu Samir and the taxi driver – perhaps readying himself to steer the conversation in a safer direction – but ultimately he did nothing to intervene. The structure of the conversation precluded the necessity of doing so. The taxi driver and probable Hezbollah fighter, for one, had begun the conversation explicitly recognizing Abu Samir as a sick man, saying *Salamtak, salamtak hajje*. The taxi driver connected Abu Samir's sickness to his and his wife's personal circumstances of illness and injury, solidifying the acknowledgement that Abu Samir was marked as a genuinely vulnerable subject. Second, the explicitly sectarian (anti-Sunni) language indicated that the taxi driver assumed Abu Samir was likewise Shia – a common assumption among Beirutis towards Iraqi visitors given the country's association with Shia symbolism and history. Perhaps most crucially, Haitham and Abu Samir generally attributed a different status to Shia military and political actors located in Lebanon versus those based in Iraq. The Hezbollah units in Beirut could not act with the same degree of impunity as the Hezbollah Brigade and PMF units in Iraq. The roadways in south Beirut were mostly "safe" (*aman*) in Haitham's view. Haitham kept his eyes on the interaction between the taxi driver and Abu Samir out of protective habit, but ultimately sensed that the threat would not materialize.

While Haitham's watchful stance in the back of the taxi indicated his sensitivity to Beirut's political landscape and its implications for his uncle, one can also note hints of a draining in Haitham's capacities to engage new contacts, relations, and encounters. It was Abu Samir who handled engagements with the taxi driver and Abu Wissam while Haitham stood to the side. Was Haitham withdrawing from the scene of care, or was this subdued disposition in line with Abu Samir's expressed needs and preferences? Let us explore this theme further in the following section.

If You Fasted

In the morning we awoke around 7:30am. It was time for chemotherapy. Upon entering the gleaming oncology center, we passed by several Iraqi families dressed in the attire distinctive of the south. Abu Samir greeted them, and then knowingly navigated a series of turns in the hallways back to an administrative office. Haitham followed behind Abu Samir. Abu Samir conferred with a nurse who instructed him to proceed to the treatment floor. 15 to 20 treatment chairs and curtained cubicles were positioned around a center cluster of desks for nurses and doctors. Adorning the administrative cluster were posters and pictures: a picture of a forest with light breaking through; a picture of golden clouds at daybreak; single frames of words such as "peace" (*Salam*), "hope" (*Amil*), "trust" (*Thiqah*), "attention" (*Ihtimam*), "joy" (*farah*).

Haitham let Abu Samir handle interactions with the doctor. Despite this ceding of control over patient-doctor engagement, Haitham would arise when Abu Samir proclaimed a specific need for him. Abu Samir would simply pronounce "Haitham", followed by a brief request. "Haitham, I want to recline." "Haitham, *yallah* bathroom."

"Haitham, rip off the bandage." "Haitham, bring the trash basket, vomit." "Haitham, the lock [on the IV's wheels]." Haitham fulfilled the task efficiently and without asking Abu Samir anything. When Abu Samir vomited, Haitham held out the basket to his left side. He waited for Abu Samir to finish. He wiped Abu Samir's mouth of vomit residue. Haitham's utterances were sparse during these tasks and concerned to the immediate matter at hand: "You want me to lower the basket?"

As we reached the third hour of chemotherapy, Haitham complained about the temperature in the room but doggedly insisted upon maintaining abstinence from water or food. Sensing my surprise (because he does not normally fast during Ramadan), Haitham leaned forward and spoke with a half whisper to avoid the earshot of Abu Samir, who was half awake at the moment: "There's a saying, 'if you fasted, goodness will come upon you (*itha sumtom, kheyr lakom*).'" He added that he was referring to the potential benefit fasting might bring to Abu Samir's treatment. "I mean, maybe it will help," he said while leaning over in Abu Samir's direction. Abu Samir continued sleeping. As we left the hospital and found a cafe nearby, Haitham's repeated refusal to join in the meal prompted a brief tirade from Abu Samir about his behavior during the previous two trips to Beirut: "Haitham I'll tell you, 15 days we were here last time and 15 days you slept in the apartment! Why come here if you are going to sleep all the time?" Haitham kept walking forward and didn't respond. We returned to the hotel, and Haitham slept.

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Abu Samir did not receive Haitham's abstinence from food in the way that Haitham had hoped. Abu Samir interpreted Haitham's fasting as a means for furthering his social withdrawal, and not as a gesture of piety towards the benefit of his health. It is

important to understand Abu Samir's broader stance towards fasting. Abu Samir often used the phrase Haitham uttered above ("if you fasted, goodness will come upon you") to justify why he had *never* taken up the Ramadan practice of fasting, as the verse does not suggest condemnation for omission but rather additional benefit for those who obey. Abu Samir understood fasting as an important practice from the standpoint of Islam — a "duty" (*wajib*); yet he qualified that it was impractical for men of his trade and circumstance. He cited the circumstances of "displacement" (*nazooh*), the toils of agricultural "work" (*shughl*), and the pains of illness as justification for eating during the holy month. Abu Samir often spoke of how fasting was easy for landowners or city people who didn't have to endure "work and weariness" (*shughl wa ta'ab)*, instead spending the whole day "under the air conditioning". He interpreted Haitham's declarations of an intention to fast in Beirut along the same lines: Haitham was using the fast to obscure a retreat from the "work and weariness" of the *murafiq* role.

In the scene above, we see how Haitham remained at Abu Samir's side and responded to all of Abu Samir's pleas for assistance in the chemotherapy ward ("Haitham, bathroom…"). But the sense that Haitham had become a slack *murafiq* in trips to Lebanon would remain and grow. Abu Samir's disappointment in his nephew arose from the neglect of the outward facing and protective dimension of the *murafiq* role. I have shown that, perhaps ironically, Haitham's felicitous execution of the outward-facing aspect of the *murafiq* role in 2014 relied upon a social trajectory that constantly drew him *away* from Abu Samir's immediate presence.

Conclusion

In this chapter I have viewed Abu Samir's journey for cancer care through the struggles, relationships, and social world of his longtime *murafiq.* The argument complicates paradigmatic notions of male caregiving through an exploration of the *murafiq* role. Previous studies on male caretaking focus on a simplistic division between managerial (male) and nurturing (female) roles. More recent studies complicate this gendered division but still preserve a focus on the managerial/nurturing functions of the caregiver. The *murafiq* role is, in contrast, normatively male. It is a temporally circumscribed function, emerging in trajectories of accompaniment outside the home, and ceasing upon return to the domestic. Crossing borders for treatment complicates traditional expectations of the *murafiqeen* as an outward facing role, thrusting them into a situation where the only means to preserve boundaries between "work" and "non-work" is to engage in male relations with other *murafiqeen.* Departing from the hyper-masculinity implicit and explicit in previous studies of homosociality, I emphasize expressions of shared vulnerability as integral to the forging of these bonds. However, the intensity of these friendships and accumulated pains of departures over the course of chronic illness render the possibility of forging and re-forging new ties increasingly fraught. Roles reserved to men and women are not only a matter of tradition but have been affected by changes due to war, occupations, and the resulting dislocations.

Postscript: Another Displacement

During the middle of dissertation writing I heard from phone calls that the three households were forced to uproot and move again for fear of the a PMF invasion into

Erbil. The Kurdish referendum for independence in October 2017 sparked a military conflict between the Iraqi Army/*hashd shaabi* (PMF) on one side and the various segments of the Kurdish peshmerga on the other. When Kurdish President Masoud Barzani and his associates refused to back down from the pro-independence results of the referendum, the PMF invaded Kirkuk city just 35 kilometers south of Abu Samir's farm, and subsequently pressed up to the town of Altun Kobri, a mere three kilometers away. The PMF now threaten to cross the "ditch" (*hufr*) into the rural periphery of Erbil province — the very site of the three households. With the threat of this crossing looming, one night they collectively moved to the town of Qoshtapa, approximately 25 kilometers northward in the direction of Erbil city. They settled into a single home with the other two households, cramming dozens of people into a single space. As they feared the further advancement of the PMF, every morning they loaded their essentials into one of the three farming trucks in the event that the group needed to move once again. Over the course of the next six weeks, the women remained in Qoshtapa while the men traveled daily to the three plots and worked to maintain the crops. Haitham acted as the primary driver and courier.

Even as the three households gradually returned to their plots once the military standoff abated, long-term impacts of the conflict would linger, with major implications for Abu Samir's treatment. In response to the Kurdish insistence upon maintaining the pro-independence referendum results, Prime Minister Hayder Al Abadi mandated the closure of the Erbil airport to international flights. Abu Samir could no longer travel to Beirut for treatments. His departures from the farm were now limited to half-day periods for chemotherapy or examinations in Erbil. Haitham reoccupied the temporally-bound

murafiq role. The cutting off of Beirut had implications across the kinship network. No longer devoting funds to Abu Samir's treatment, modes of domestic triage shifted. For two years I had been told that the children of the three households could not attend school because the daily expense of transportation and supplies would be too great. After three months of hiatus from Abu Samir's treatment in Beirut, they started attending school.

Abu Samir (once again) now made assertive moves towards securing their long-term inhabitation in Erbil. This time his efforts were less focused on securing a new household head (in Samir) and more on securing the contractual hold over land. The only way to move out of sharecropping was through land rentals on an annual contract. For the first three years of the displacement period (2014-2017), the vast majority of Arab displaced farmers resisted making the move towards rentals under the logic of the potential for lost investment upon eviction. After the KRG's failed confrontation with Baghdad and PMF over the independence referendum in October 2017, there was a growing sense among displaced Arabs that wholesale eviction of the Arab population would be a political impossibility for the now vulnerable Kurdish political class.

Abu Samir saw an opportunity and decided to search for rental properties. The economic capacity to do so was partly a function of his inability to travel to Beirut for treatments. No longer making regular payments for private care in Lebanon, he had saved considerable funds. Abu Samir ultimately established an arrangement with a Kurdish man who offered 60 donums for $6000/year. When I visited the plot briefly in the spring of 2018, I took a stroll with Abu Samir and his longtime companion Haitham. Abu Samir noted that only a 200-meter expanse of dirt road separated his house from that of his new landlord. He pointed, saying, "That's the house of the Kurdi". No longer linked through

profit sharing, Abu Samir barely interacted with the Kurdish landlord and his family. The wife of the Kurdish landlord passed by us and nodded, uttering brief greetings. She joined the line of Abu Samir's girls and helped them pick up and bag a few watermelons. "She just enjoying herself (*twanis*), nothing more," Abu Samir assured me. When Abu Samir was a tenant, any visit from a family member of the Kurdish landlord bore a double sense, perhaps conveying neighborly conviviality and perhaps distrustful monitoring. For now, Abu Samir could remove this uncertainty from his field of concerns.

CONCLUSION

This dissertation has explored Iraq's emerging geography of cancer care through singular journeys across cities, provinces, and borders. Part I examines this geography from the vantage point of two important nodes: Kurdish Iraq and Beirut, Lebanon. In chapter 1, the exploration of journeys to the Kurdish north has opened up questions of scale. The data in the chapter stresses how the experience of chronic illness amidst mobility defies preconfigured scalar divisions. Borders, checkpoints, and roadways are embedded within experiences of care. A robust phenomenology of therapeutic geographies must include this ground-up understanding of scale. Chapter 2 documents cross-border journeys to Beirut and examines the accumulation of cost in and through treatment itineraries, both those which are exclusively funded through kinship networks and those that rely upon government support. Whereas the current conversation in oncology on "financial toxicity" assumes a socio-economic context of stability which cancer enters and definitively disrupts, in Iraq high-cost cross-border cancer treatment enters into an already unstable political economy of families and communities suffering a lengthy series of disruptions. Any attempt to understand and assess "financial toxicity" must account for the ways in which cancer treatment strips resources that are already and continuously drained under long-term, ongoing conditions of war.

Part II consists of an elaborated case study of a single cancer trajectory. Chapter 3 takes the question of cost-accumulation into a specific kinship network from which these resources are drawn. I show how the kinship network moves through justifications for either granting or withholding resources. As the patient struggles to make preparations for a death that he regards as imminent through the securing of resources and a marriage for

his son, ultimately it is not his status as a sick man but rather the loss of his home in conflict that grants him recognition as worthy of cross-household support. Amidst war and displacement people do not have sufficient access to context in order to formulate or forecast such justifications in advance. Consequently, any attempt to understand such logics requires careful ethnographic elaboration within the encounters, sites, and struggles in which they take shape. Chapter 4 moves from the question of cost to matters of care, exploring cancer journeys through the labors of the "companions" (*murafiqeen*). As the *murafiq* role is threatened with temporal expansion when long-term and repeated travel across borders removes the domestic point of return, the old boundary between work and non-work is reanimated through male sociality among fellow *murafiqeen.* This sociality is constituted through a forgetting of the toil of caregiving and a remembering of violence in Iraq. It is perhaps fitting that chapter 4 ends on this point: In each of the chapters and across the two parts, both memories and ongoing experiences of war impinge upon and shape the trajectory and texture of care. A journey for treatment draws together borders, resources, persons, memories and experiences of war, and the struggles to live on.

Following a singularity in an ethnographic mode allows us to track out an intricate transnational network of institutions and actors distributed across an emerging geography – and this network includes, crucially, numerous other persons engaged in similar trajectories of care. We see the coming together of such a network in chapter 4 as Abu Samir and his companion develop relationships and draw upon the assistance of other Iraqis converging in Beirut. One journey becomes intertwined with dozens of

others. A singular experience draws together a network of relations that give the impression of a larger socio-spatial phenomenon.

What exactly is this something larger? While the dissertation focuses on the emergence of a geography of cancer care, the material also speaks to the making and remaking of the region – the Middle East. In the five years of my doctoral research, the major cities where I have conducted fieldwork have undergone enormous change. Erbil has emerged as a refuge for over a million displaced persons. Beirut now hosts hundreds of thousands of Syrians. While this refugee style migration and displacement is immense, it is important for researchers to understand a broader phenomenon of mobile lives. Displacements of populations are coupled with the movement of persons across borders for healthcare, education, and trade. For many, living, dying and surviving in the Middle East involves a regional life trajectory. Instead of the formal reconstruction of institutions people have pieced together means of accessing services through movement. A region that has received the brunt of the US-led war on terror has simultaneously absorbed that violence, in part through a reformulation of the local. In chapter 4 we see the familiarity with which Abu Samir navigates Beirut's streets, hotel owners, nurses, and doctors even with the withdrawal of attention from Haitham. It is altogether possible that Abu Samir will eventually meet his demise during a treatment stint in Beirut. Where people work, undergo treatments, and die must be taken into account in our imagination of Iraq and of the region. Highlighting the everydayness of this mobility is not to say that this undoing and reworking of borders does not generate distress and suffering. The seemingly endless temporal and spatial extension of a mobile life can also corrode and darken the everyday, as we saw with Haitham's growing distaste for Beirut.

This brings us to the question of the place of war in the dissertation, and specifically, the form of war prosecuted and led by the United States since 1991. In Dewachi et al. 2014, we looked to US-led wars primarily in relation to medical institutions. Throughout the 1980s Iraq and Iran were engaged in a protracted 8-year conflict that led to the deaths of 2 million men, but the fighting largely remained along the borders of the two countries and key state institutions remained intact. In 1991, over the span of a few days the US air force effectively destroyed Iraq's electricity grid, water supplies, and crippled hospital networks. The sanctions that followed prevented their maintenance and resupply. The 2003 invasion brought violence into civilian spaces including hospitals, and pushed doctors and nurses across borders, furnishing the ground for the reworking of Iraq's therapeutic geographies. The analysis of how war destroys and remakes medical institutions remains central to the dissertation, but the centrality of patients' experience in this thesis has given greater weight to the question of how war generates particular fears, anxieties, hopes in the unfolding of a journey for care.

While following patients along a *journey* brings a certain unity to the dissertation, there is simultaneously a distinction in method, style, and approach between the two halves. Part I contains ethnographic elements in that I have attempted to move beyond the hospital-based interview and accompany patients across borders and into the spaces of residency such as the Weekend Hotel. Yet while I draw from ethnographic approaches, the chapter has sought to retain recognizability within the methodological and writing conventions of oncologists and health practitioners. I break up my materials into 'cases' and engage largely with medical and public health scholarship. As mentioned in the introduction, the genesis of this approach came in an early encounter with a senior Iraqi

oncologist who reviewed my research methodology and expressed the importance of developing a more systematic qualitative method. In the end we developed a mutually satisfactory interview approach together.

I am grateful for his intervention. Over the past several years, partnerships with Nanakali Cancer Hospital, Hiwa Cancer Hospital, Kirkuk Cancer Center and the American University of Beirut Medical Center have been fruitful, worthwhile, and characterized by mutual respect across disciplines. As we have published in medical rather than social science journals (See Dewachi et al. 2014; Skelton et al. 2017), I have witnessed with pleasure the extent to which medical practitioners take such research seriously and attempt to push findings into framings of 'best practices' and policy at the institutional level. One product of the Dewachi et al. (2014) article combined with the persistence of the lead author has been a significant reformulation of medicine at the American University of Beirut Medical Center, considered the top hospital in the Middle East. The hospital is now increasingly oriented towards situating itself to a region of war and displacement, rather than engaging the patient population according to strictly American protocols. As part of this broader effort, the oncology department with the leadership of Deborah Mukherji is now participating in researching and ultimately (hopefully) shifting financial arrangements for the war-affected population.

Where I have found this mode of research more complex is when the implementation side attempts to move outside the orbit of specific medical institutions. In April 2017 myself and several Iraqi oncologists penned an article laying out a research and policy agenda for addressing the health care mobilities of IDPs outlines in chapter 1. As an outgrowth of this research, we co-organized a policy stakeholder roundtable at an

Iraq-based think tank, with a specific focus on Mosul and the complex referral pathway between Mosul IDP camps and Erbil hospitals. We attempted to convene all the major actors along the referral pathway: Those signing off on referrals (doctors); facilitating ambulance transport (WHO and IRC); presiding over checkpoints (Kurdish and Iraqi security forces); and finally health care authorities (Kurdish and Iraqi ministries of Health). On the day of the roundtable, IRC and UNHCR representatives described how ambulance drivers, whether they were employees of the Iraqi Ministry of Health or WHO, were instructed first to go to a Mosul IDP camp, obtain a signature from the security officer, then the camp manager, and then proceed to the checkpoint where one or more of the patients could be refused entry into the KRG and Erbil's public hospitals. These stops constituted major delays. After describing the problem, the conversation moved organically towards talk of "recommendations." Our final report mentions the recommendation of a cross-agency coordinating mechanism for making appeals for specific patients. [72] Though this mechanism was never seriously pursued, colleagues assured me that we had started an important "conversation." To me this output seemed nearly indistinguishable from the world of academic conferences with which I was more familiar. I will continue to explore this question I now move into a research position oriented towards policy.

Part II is an attempt to convey a singular illness journey through an ethnographic mode of engagement. This segment of the thesis is a reflection both of my life and those of the persons described, as I have become bound to the patient and kinship network in

[72] Skelton M, Talabany, SK: War, Health & Refugees in Iraq: Stakeholder Meeting Report. Sulaimani, Iraq, The Institute of Regional and International Studies, American University of Iraq-Sulaimani, 2017

intimate ways that have generated long-term friendships, exchanges, and mutual obligations. The relations and encounters described in part II remain part of my everyday both in memory and in the present, as individuals 70-person kinship network constantly contact, cajole, and encourage me through texts, calls, and invitations to visit. Up to the last day and hour of the official IRB closure of the study in May 2018, I was making revisions to the content based on new and unfolding events. This sense of contingency and open-endedness is, I hope, reflected in the ethnography, revealing an illness journey as unfolding unpredictably and across always unanticipated fields of relations.

Arthur Kleinman (1988) hinted at this indeterminacy beautifully: "I prefer patients' images of the journey through limbo...The chronically ill often are like those trapped at a frontier, wandering confused in a poorly known border area, waiting desperately to return to their native land. Chronicity for many is the dangerous crossing of the borders, the interminable waiting to exit and re-enter normal everyday life, the perpetual uncertainty of whether one can return at all" (1988: 181). Where my conception of the 'journey' departs from the one envisioned by Kleinman is the methodological mode of engagement with its unfolding. Kleinman, acting as part anthropologist and part clinician, tracks the illness across time and social relations in order to construct what he calls an "ethnography" of an "illness narrative" (1988: 233), yet methodologically he does so retrospectively and through the articulations of patients and their caregivers. Part II of this dissertation draws inspiration from Das (2015) in suggesting that the passages through illness frontiers and the workings of relationships are too inchoate and variable to find adequate expression through such methods. When the sick convey illness in speech within the clinic, they package it within certain recognizable forms (procedure, price,

misdiagnosis) and leave out other dimensions which do not conform to the temporal, spatial, and power dynamics of the clinical interview. This is not to diminish the importance and usefulness of interview-based methods in medical anthropology. There is however a need for a distinction between the kind of account available through a clinical interview and the multi-dimensional material available to an anthropologist situated within a patient's life world.

Understanding the burdens of war on families and communities requires transnational frameworks and methodologies that span a lengthy research period. Illness itineraries are important lenses into transnational processes of war as they map out assemblages of institutions, relationships, and social spaces across a region. While the attention granted to refugee style migration is understandable given its political implications, it is important for researchers to understand how individuals and families continuing to reside within the Middle East region have also engaged in life trajectories involving cross-border mobilities. These movements within the region are painfully undertheorized, and thus the paradigmatic scholarly discourses of humanitarianism remain tethered to European frameworks. Scholars studying regions transformed by war must explore mobilities that are not oriented around the hopes of leaving and securing citizenship elsewhere but rather the hopes of remaining and ensuring that the world is left inhabitable for one's progeny. Abu Samir and countless others continue in a struggle towards this horizon.

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Zhang, Q., Northridge, M. E., Jin, Z., & Metcalf, S. S. (2018). Modeling accessibility of screening and treatment facilities for older adults using transportation networks. *Applied geography*, *93*, 64-75.

CURRICULUM VITAE

Education

2018 PhD (confer 12/2018), Anthropology, Johns Hopkins University, Baltimore, MD

2012 MA, Anthropology, The American University of Beirut, Beirut, Lebanon

2007 BA, Religion *magna cum laude*, Davidson College, Davidson, North Carolina

Publications

Peer Reviewed Journals

2018 Caduff, Carlo, Skelton, Mac, Dwaipayan Banerjee, et al. Cancer Care in Low & Middle- Income Countries: Social Science Perspectives. *Journal of Global Oncology.* June.

2017 Skelton, Mac; Mula-Hussein, Layth; Namiq, Kazim F. Oncology in Iraq's Kurdish Region: Navigating War, Displacement and Cancer. *Journal of Global Oncology.* April.

2014 Dewachi, Omar; Skelton, Mac; Nguyen, VK, et al. Changing Therapeutic Geographies of the Iraq and Syrian Wars, *The Lancet*, February.

Book Chapters

2018 Skelton, Mac. Iraqis' Cancer Itineraries: War, Displacement, and Therapeutic Geographies. In *War and Health*, Catherine Lutz and Andrea Mazzarino, eds. NYU Press (in press)

Other Publications

2017 Skelton, Mac; Talabany, S. War, Health & Refugees in Iraq: Stakeholder Meeting Report. The Institute of Regional and International Studies. American University of Iraq-Sulaimani. August.

2013 Skelton, Mac. Health and Healthcare Decline in Iraq," Brown University, Watson Institute, Costs of War Project. April.

Grants and Fellowships

Andrew Mellon IDRF Fellow, Social Science Research Council, 2016–2017
US Scholar Fellowship, American Academic Research Institute in Iraq, 2016–2017
FLAS Academic Year Grant, US Department of Education, 2015–2016
FLAS Summer Language Grant, US Department of Education, 2015

Islamic Studies Program Research Grant, Johns Hopkins University, 2015
Owen Fellowship, Johns Hopkins University, 2013–2016

Conference Activity

Panels Organized

2017 Time and the Event in the Anthropology of the Middle East. Co-Organizer. American Anthropological Association Annual Meeting, November 29.

2016 Experiencing Movement and Migration in the Middle East. Organizer and Co-Chair. American Anthropological Association Annual Meeting, November 17.

Papers Presented

2017 We are all psychiatrists: Articulations of Palliative Care under Conflict. Middle East Studies Association Annual Meeting. Washington, DC. November 21.

2017 Iraqis' Cancer Journeys: Hope, Displacement, and the Time Remaining. American Anthropological Association Annual Meeting, Washington, DC. November 17.

2017 Displaced Cancer Patients in the Kurdish Region of Iraq: War, Access, and Movement. Global Conflict Medicine Congress. Middle East Medical Assembly. American University of Beirut Medical Center. Beirut, Lebanon. May 14.

2016 Transnational care-seeking under conflict: War, Mobility, & Aspiration. The American Anthropological Association Annual Meeting, November 20.

Invited Talks

2018 Geographies of Displacement and Care. Workshop convened by Dr. Carlo Caduff. King's College London. London, United Kingdom. May 17.

2016 War and Healthcare in Iraq: 1980-2016. The Institute of Regional and International Studies. American University of Iraq-Sulaimani. Sulaimani, Iraq. Dec. 5.

2016 "Iraqis' Cancer Journeys: Palliative Care, War, Movement." The Anthropological Society in Lebanon. Beirut, Lebanon. American University of Beirut. September 18.

Public Engagement

2017 War, Health, and Refugees: A Stakeholder Roundtable. Institute for Regional and International Studies. Sulaymaniyah, Iraq. April 27. (Organizer and Moderator)

2014 Iraq: War and Everyday Life. Community forum. Sponsored by the Costs of War Project, Brown University. Washington, DC. October 28 (Speaker)

2013 Roundtable with H.E. Lukman Faily, Ambassador of Iraq to the United States. Business Council for International Understanding. NY, NY. May 24. (Organizer and Moderator)

Teaching

Maryland Institute College of Art

Introduction to Cultural Anthropology (Instructor of Record, 2017)

Johns Hopkins University

Iraq: War & Everyday Life (Instructor of Record, winter 2015)
Introduction to Islam and Muslim Societies Since 1800 (TA/Section Leader, 2015)
Anthropology of Mental Illness (TA/Section Leader, 2014)
Introduction to Anthropology (TA/Section Leader, 2014)